

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23001

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Lillie Branch</i>				2. Date of Death Month <i>July</i> Day <i>15</i> Year <i>1996</i>		3. Time of Death <i>11:30 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>North Charles Healthcare Center</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>none</i>	
Funeral Director	5. Social Security Number <i>219-39-1354</i>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>91</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>May 5, 1905</i>	
	9. Birthplace (State or Foreign Country) <i>North Carolina</i>		10a. State <i>Maryland</i>		10b. County <i>none</i>		10c. City, Town or Location <i>Baltimore</i>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <i>2700 N. Charles Street</i>		10f. Zip Code <i>21218</i>		10g. Citizen of What Country? <i>U.S.A.</i>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>unknown</i> College (1-4or 5+) <i>unknown</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>unknown</i>		16b. Kind of Business/Industry <i>unknown</i>			
	17. Father's Name (First, Middle, Last) <i>unknown</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>unknown</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Rose Taylor/Niece</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1617 N. Broadway-Baltimore, Maryland 21203</i>			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) <i>State rem.</i>		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee <i>Ronald S. Wade Dir.</i>				22. Name and Address of Facility <i>State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559</i>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				23b. Approximate Interval Between Onset and Death <i>pneumonia</i> Due to (or as a consequence of): <i>intercerebral bleed</i> Due to (or as a consequence of): Due to (or as a consequence of):		3 days 3 mos	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>DM, CAP, CRF</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		
28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>D37578</i>		
29d. Date signed (Month, Day, Year) <i>July 15 1996</i>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Jeff Zibell MD 7220 Park Heights Ave Baltimore MD 21208</i>		31. Date filed (Month, Day, Year) <i>AUG 05 1996</i>		32. Registrar's Signature <i>[Signature]</i>		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

96 23002

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Rosa Blalock						2. Date of Death Month Day Year Aug. 04, 1996		3. Time of Death 8:00pm	
	4a. Facility Name (If not Institution, give street and number) 3922 Fait Avenue						4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 216-34-7534		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 59 Yrs.		8. Date of Birth (Month, Day, Year) June 19, 1937		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 3922 Fait Avenue				10f. Zip Code 21224		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) College				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Vernon Ware Clark						18. Mother's Name (First, Middle, Maiden Surname) Grace Disney			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Oscar Neal Blalock/son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3922 Fait Avenue Baltimore, MD 21224					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		Date 8/5/96		20c. Location - City or Town, State Baltimore, MD			
	21. Signature of Funeral Service Licensee George E. MacNabb				22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228					
	23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ovarian Carcinoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 14 years									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Multiple myeloma										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier G. Scott Long, M.D. Medical Oncology Fellow				29c. License number D46331		29d. Date signed (Month, Day, Year) August 5, 1996				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) G. Scott Long, Johns Hopkins Oncology Center, 600 N Wolfe St, Baltimore MD 21287										
31. Date filed (Month, Day, Year) AUG 05 1996		32. Registrar's Signature Don-Randall								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

96 23003

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) Carol Kegley BURNS				2. Date of Death Month Day Year August 1, 1996		3. Time of Death 11:20 a.m.	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital				4b. City, Town, or Location of Death Essex		4c. County of Death Baltimore County	
Funeral Director	5. Social Security Number 213-40-1604		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 54 Yrs.		8. Date of Birth (Month, Day, Year) March 2, 1942	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Rosedale	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 2 Parham Circle, Apt. TB		10f. Zip Code 21237		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedant Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedant of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) 2		16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse		16b. Kind of Business/Industry Nursing Home			
	17. Father's Name (First, Middle, Last) Frank Michael Whalen				18. Mother's Name (First, Middle, Maiden Surname) Mary Prichard			
	19a. Informant's Name/Relationship (Type, Print) Lori A. Leeper/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5310 Castlestone Dr. Rosedale, MD 21237			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. 08/02/96		20c. Location - City or Town, State Baltimore, MD			
	21. Signature of Funeral Service Licensed George E. MacNabb		22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstructive Pulmonary Disease Dua to (or as a consequence of): b. Dua to (or as a consequence of): c. Dua to (or as a consequence of): d. Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier M. K. M.D.				29c. License number 045475		29d. Date signed (Month, Day, Year) 8-1-96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohammad Rahnema M.D. 19 Fontana Lane #102 Baltimore, MD 21237								
31. Date filed (Month, Day, Year) AUG 05 1996		32. Registrar's Signature Handell						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23004

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Case Blough

2. Date of Death

August 01 1996

3. Time of Death

10:36 AM

4e. Facility Name (If not institution, give street and number)

420 Hillview Dr., Apt. 301

4b. City, Town, or Location of Death

Linthicum Heights

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

213-26-3640

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

AUG 26, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Linthicum Heights

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

420 Hillview Dr., Apt. 301

10f. Zip Code

21090

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates: Korean Conflict

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Lithographer

16b. Kind of Business/Industry

Printing Industry

17. Father's Name (First, Middle, Last)

Joseph Berkey Blough

18. Mother's Name (First, Middle, Maiden Surname)

Frances Case

19a. Informant's Name/Relationship (Type, Print)

Frances Marie Wilson/sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

39 Reile Drive Elkridge, MD 21227

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 08/02/96

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licenses

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 21228

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Emphysema
cancer of the lung

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

10 year
2 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

cardiomyopathy

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Sarah

29c. License number

D21928

29d. Date signed (Month, Day, Year)

August 2nd/96

30. Name and address of person who completed cause of death (item 23e) (Type, Print)

LEONEL BARAHONA 3459 St Johns Lane 21042

31. Date filed (Month, Day, Year)

AUG 05 1996

32. Registrar's Signature

John Handell

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

96 23005

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HENRY B. BROWN				2. Date of Death Month JULY Day 29 Year 1996		3. Time of Death 1605 PM	
	4a. Facility Name (If not institution, give street and number) 1304 ANGLESEA STREET				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 220-22-8730		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) Sep. 28, 1927	
	9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10e. Street and Number 1304 Anglesea Street Apt. T1		10f. Zip Code 21224		10g. Citizen of What Country? United States		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Shipyard		16b. Kind of Business/Industry Bethlehem Steel		17. Father's Name (First, Middle, Last) Howard Brown	
	18. Mother's Name (First, Middle, Maiden Surname) Estella Young		19a. Informant's Name/Relationship (Type, Print) Sandia A. Bond		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 526 W. 5th Street, Plainfield, N.J. 07060		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Cemetery		20c. Location - City or Town, State Baltimore, Maryland		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility March Funeral Home 1101 E. North Avenue, Baltimore, MD 21202	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
State Registrar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 	
To Be Completed by Physician/Medical Examiner	29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) JULY 30, 1996		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201		31. Data filed (Month, Day, Year) AUG 05 1996	
	32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23007

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PATRICIA S. BALDO						2. Date of Death Month Day Year JULY 31, 1996		3. Time of Death 6:14 AM														
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL						4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A														
Funeral Director	5. Social Security Number 080-44-8029		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 40 Yrs.		8. Date of Birth (Month, Day, Year) APR 26, 1956		9. Birthplace (State or Foreign Country) New York														
	Usual Residence of Decedent																						
To Be Completed by Funeral Director	10a. State NY		10b. County Otsego		10c. City, Town or Location West Oneonta				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
	10e. Street and Number P.O. Box 1				10f. Zip Code 13861		10g. Citizen of What Country? USA																
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white															
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+)				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered School Nurse			16b. Kind of Business/Industry Elementary School															
	17. Father's Name (First, Middle, Last) Francis Sweeney						18. Mother's Name (First, Middle, Maiden Surname) Margaret Gimber																
	19a. Informant's Name/Relationship (Type, Print) Anthony M. Baldo - husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 1, West Oneonta, New York 13861																		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Calvary Cemetery		Date 8/03/96		20c. Location - City or Town, State Emmons, New York														
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227																		
	23a. Pertinent to the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																						
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. ACUTE MYOCARDIAL NECROSIS</td> <td>ONE DAY</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b. OVARIAN CANCER</td> <td>EIGHT MONTHS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a. ACUTE MYOCARDIAL NECROSIS	ONE DAY	Due to (or as a consequence of):		b. OVARIAN CANCER	EIGHT MONTHS	Due to (or as a consequence of):		Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c.		d.
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE MYOCARDIAL NECROSIS	ONE DAY																					
	Due to (or as a consequence of):																						
	b. OVARIAN CANCER	EIGHT MONTHS																					
	Due to (or as a consequence of):																						
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c.																						
	d.																						
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred														
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																						
	29b. Signature and title of certifier  m.o.				29c. License number N9197		29d. Date signed (Month, Day, Year) JULY 31, 1996																
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KRAIG KINCHEN 6816 BONNIE RIDGE DRIVE APT 102, BALTIMORE, MD 21209																						
	31. Date filed (Month, Day, Year) AUG 05 1996																						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23008

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>SHIRLEY BOOKER</u>				2. Date of Death Month <u>AUGUST</u> Day <u>1</u> Year <u>1996</u>		3. Time of Death <u>6:10 pm</u>		
	4a. Facility Name (If not institution, give street and number) <u>JOHNS HOPKINS HOSPITAL</u>				4b. City, Town, or Location of Death <u>BALTIMORE</u>		4c. County of Death <u>N/A</u>		
Funeral Director	5. Social Security Number <u>228-26-1334</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>70</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>January 16, 1926</u>		
	9. Birthplace (State or Foreign Country) <u>Virginia</u>		10a. State <u>Maryland</u>		10b. County <u>N/A</u>		10c. City, Town or Location <u>Baltimore</u>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <u>1804 Bond Street</u>		10f. Zip Code <u>21213</u>		10g. Citizen of What Country? <u>United States</u>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Minister</u>		16b. Kind of Business/Industry <u>Church</u>					
17. Father's Name (First, Middle, Last) <u>William Booker</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Parkie Brightwell</u>					
19a. Informant's Name/Relationship (Type, Print) <u>Ruth A. Booker/ Wife</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1804 Bond Street Baltimore, Maryland 21213</u>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Cedar Hill Cemetery</u>		Date <u>8/6/96</u>		20c. Location - City or Town, State <u>Glen Burnie, Maryland</u>			
21. Signature of Funeral Service Licensee <u>Brian A. Willem</u>				22. Name and Address of Facility <u>Leonard J. Ruck Funeral Home, Inc. 5305 Harford Road Baltimore, Maryland 21214</u>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>MYOCARDIAL INFARCTION</u> Due to (or as a consequence of): f. <u>CORONARY ARTERY DISEASE</u> Due to (or as a consequence of): g. <u>DIABETES MELLITUS</u> Due to (or as a consequence of): h. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate interval Between Onset and Death <u>30 min.</u> <u>2 years</u> <u>10 years</u>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29f. Signature and title of certifier <u>SHIRLEY RESIDENT</u>		29g. License number <u>N1281</u>		29h. Date signed (Month, Day, Year) <u>AUGUST 1, 1996</u>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>RICHARD WALKER, JOHNS HOPKINS, 600 NORTH WOODFORD ST., BALTIMORE, MD 21287</u>									
31. Date filed (Month, Day, Year) <u>AUG 05 1996</u>		32. Registrar's Signature <u>John Anderson</u>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23009

ITEM#4c film g738 8/5/96ag perFH

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Virginia Brownley

2. Date of Death

August

Day

Year

3. Time of Death

0835

4a. Facility Name (If not institution, give street and number)

Mercy Hospital, 301 St. Paul Street

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

218-26-7431

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Sept. 28 1909

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2102 Anthony Avenue

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Thaddeus Fitzhugh Morgan

18. Mother's Name (First, Middle, Maiden Surname)

Harriett E. Greene

19a. Informant's Name/Relationship (Type, Print)

Carolyn Bronushas (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2104 Rosalie Avenue Essex, Md. 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Haynes Cemetery

Date

8/07/1996

20c. Location - City or Town, State

Cobbs Creek, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdinski Funeral Home P.A.

1407 Old Eastern Ave., Essex, Md. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Coronary Artery Disease

Due to (or as a consequence of):

HTN

Due to (or as a consequence of):

DVT

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 days

15 years

4 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Vijay Pethkar MD

29c. License number

050853

29d. Date signed (Month, Day, Year)

8/4/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vijay Pethkar MD 301 St. Paul Place, Baltimore MD 21202.

31. Date filed (Month, Day, Year)

AUG 05 1996

32. Registrar's Signature

Julia Davidson

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

On the 12th of May 1944, the following were observed:

1. A large number of small, dark, oval-shaped objects, possibly seeds or small stones, were found scattered across the ground.

2. A few larger, irregularly shaped objects, possibly pieces of wood or bark, were also observed.

3. The ground was covered with a layer of dry leaves and twigs, which may have been the source of the objects.

The objects were found in a clearing, possibly a field or a meadow, and were surrounded by a dense growth of trees and shrubs. The objects were found in a line, possibly indicating a path or a trail.

The objects were found in a clearing, possibly a field or a meadow, and were surrounded by a dense growth of trees and shrubs. The objects were found in a line, possibly indicating a path or a trail.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EDWARD L. CLINE				2. DATE OF DEATH MONTH AUGUST DAY 3 YEAR 1996		3. TIME OF DEATH 4:30 P.M.	
4. SOCIAL SECURITY NUMBER 220-09-4894		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 31, 1919	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9. COUNTY OF DEATH CECIL			
9a. FACILITY NAME (If not institution, give street and number) VA MD HEALTH CARE SYSTEM				9b. CITY, TOWN OR LOCATION OF DEATH PERRY POINT		9c. COUNTY OF DEATH CECIL	
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore Highlands		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2725 Arbutus Avenue				10f. ZIP CODE 21227		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Crane Operator		16b. KIND OF BUSINESS/INDUSTRY Cookware Manufacturer			
17. FATHER'S NAME (First, Middle, Last) Samuel Cline				18. MOTHER'S NAME (First, Middle, Maiden Surname) Molly Munchew			
19a. INFORMANT'S NAME (Type/Print) Caroline C. Cline				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2725 Arbutus Ave. Baltimore Highlands, MD 21227			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 8/5/96		20c. LOCATION — City or Town, State Baltimore, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE George E. MacNabb				22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Chronic Obstructive Pulmonary Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 2 days 5 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Thomas Finucan, M.D.				29c. LICENSE NUMBER D32395		29d. DATE SIGNED (Month, Day, Year) 08/03/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Thomas Finucan, M.D. Perry Point, MD 21902							
31. DATE FILED (Month, Day, Year) AUG 05 1996				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

870A

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

8/16/96 reb

State of Maryland / Department of Health and Mental Hygiene

96 23011

Items: 5, 9, 10b, f, 15, 16a, b, 17, 18, 20a, b, c per F.H G-738 Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Anna Clay</i>				2. Date of Death Month <i>07</i> Day <i>27</i> Year <i>96</i>				3. Time of Death <i>3:55 pm</i>	
	4a. Facility Name (If not institution, give street and number) <i>Mercy Medical Center</i>				4b. City, Town, or Location of Death <i>Baltimore</i>				4c. County of Death <i>none</i>	
Funeral Director	5. Social Security Number <i>176-16-9029</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>74</i> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <i>May 30, 1922</i>		9. Birthplace (State or Foreign, Country) <i>Pennsylvania</i>		10a. State <i>Maryland</i>		10b. County <i>none</i>		10c. City, Town or Location <i>Baltimore</i>	
Usual Residence of Decedent										
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
10e. Street and Number <i>611 S. Charles Street</i>										
10f. Zip Code <i>21202</i>										
10g. Citizen of What Country? <i>U.S.A.</i>										
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced										
12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:										
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:										
14. Race - American Indian, Black, White, etc. Specify: <i>White</i>										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>unknown 4th</i> College (1-4 or 5+) <i>unknown</i>										
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>unknown</i> HOMEMAKER										
16b. Kind of Business/Industry <i>unknown</i> OWN HOME										
17. Father's Name (First, Middle, Last) <i>unknown</i> FRANK MARLOVICH										
18. Mother's Name (First, Middle, Maiden Surname) <i>unknown</i> ANNA DROSCEK										
19a. Informant's Name/Relationship (Type, Print) <i>Margaret Clay/Daughter</i>										
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>323 E. Fort Avenue-Baltimore, Maryland 21230</i>										
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>State rem.</i>										
20b. Place of Disposition (Name of cemetery, crematory or other place) <i>METRO CREMATORY, INC</i>										
20c. Location - City or Town, State <i>8/15/96 BALTIMORE, MD.</i>										
21. Signature of Funeral Service Licensee <i>Ronald S. Wade, Dir.</i>										
22. Name and Address of Facility <i>State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559</i>										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Anoxic brain injury</i> Due to (or as a consequence of): <i>Probable myocardial infarction with A-systole</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <i>Chronic obstructive pulmonary disease</i> <i>atrial fibrillation</i> <i>History of subdural hematomas</i> 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier <i>NW Todd MD</i> 29c. License number <i>D37790</i> 29d. Date signed (Month, Day, Year) <i>07/27/96</i> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Nervins W Todd 301 St Paul Place Baltimore</i> 31. Date filed (Month, Day, Year) <i>AUG 05 1996</i> 32. Registrar's Signature <i>Julia Burdick</i>										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23012

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDWARD NEELY COOK			2. Date of Death Month Day Year July 30, 1996		3. Time of Death 7:30 P.M.																									
	4a. Facility Name (If not institution, give street and number) 2407 Westport Street			4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A																									
Funeral Director	5. Social Security Number 251-38-7766	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MARCH 4, 1928																									
	9. Birthplace (State or Foreign Country) S. Carolina																														
To Be Completed by Funeral Director	Usual Residence of Decedent																														
	10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																									
	10e. Street and Number 2407 Westport Street		10f. Zip Code 21230		10g. Citizen of What Country? United States																										
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black																								
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Heavy Equipment Operator		16b. Kind of Business/Industry Construction																										
	17. Father's Name (First, Middle, Last) Neely Cook			18. Mother's Name (First, Middle, Maiden Surname) Grebilue Hood																											
	19a. Informant's Name/Relationship (Type, Print) Floretta Crudup			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2407 Westport Street, Baltimore, Maryland 21230																											
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PARK		Date 8-3	20c. Location - City or Town, State RANDALLSTOWN, MD																									
	21. Signature of Funeral Service Licensee L. Valencia Holland			22. Name and Address of Facility March Funeral Home 1101 E. North Avenue, Baltimore, Maryland 21202																											
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																														
<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="6">e. congestive heart failure Due to (or as a consequence of):</td> </tr> <tr> <td colspan="6">b. cardiomyopathy Due to (or as a consequence of):</td> </tr> <tr> <td colspan="6">c. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="6">d. Due to (or as a consequence of):</td> </tr> </table>							Immediate Cause (Final disease or condition resulting in death)	e. congestive heart failure Due to (or as a consequence of):						b. cardiomyopathy Due to (or as a consequence of):						c. Due to (or as a consequence of):						d. Due to (or as a consequence of):					
Immediate Cause (Final disease or condition resulting in death)	e. congestive heart failure Due to (or as a consequence of):																														
	b. cardiomyopathy Due to (or as a consequence of):																														
	c. Due to (or as a consequence of):																														
	d. Due to (or as a consequence of):																														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. arteriosclerosis heart disease ventricular arrhythmia																															
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																															
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																															
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																															
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																															
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																															
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred																													
28f. Location (Street and Number or Rural Route Number, City or Town, State)																															
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																															
29b. Signature and title of certifier Rifat Abousy			29c. License number D12729		29d. Date signed (Month, Day, Year) August 1, 1996																										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rifat Abousy, M.D., Garwin Med. Ctr., Balto. MD																															
31. Date filed (Month, Day, Year) AUG 05 1996		32. Registrar's Signature J. Davidson-Randall																													

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23013

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELFORD H. CALDWELL				2. Date of Death Month Day Year AUGUST 1 1996		3. Time of Death 1:30 P.M.	
	4a. Facility Name (If not Institution, give street and number) 711 FERNHILL ROAD				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 229-12-9387		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 20, 1917	
	9. Birthplace (State or Foreign Country) Virginia		10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 711 FERNHILL ROAD		10f. Zip Code 21226		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Barber		16b. Kind of Business/Industry Hair Cutting			
	17. Father's Name (First, Middle, Last) Sidney R. Caldwell				18. Mother's Name (First, Middle, Maiden Surname) Zethna Torrence			
	19a. Informant's Name/Relationship (Type, Print) Margaret G. Caldwell/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 711 Fernhill Rd. Baltimore, Md. 21226			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Cemetery		20c. Date 8/3/96		20d. Location - City or Town, State Glen Burnie, Md/	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death line. Immediate Cause (Final disease or condition resulting in death) Respiratory Failure Due to (or as a consequence of): End stage chronic obstructive pulmonary disease Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				Approximate Interval Between Onset and Death 2 months 5 years			
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23c. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D45148		29d. Date signed (Month, Day, Year) August 1, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARDO OSORNO, M.D., 3708 MOUNTAIN ROAD, PASADENA, MD 21122								
31. Date filed (Month, Day, Year) AUG 05 1996								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23014

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Willie M. Carter Jr.

2. Date of Death

Month Day Year
August 1, 1996

3. Time of Death

10:55 A.M.

4a. Facility Name (If not institution, give street and number)

VA Maryland Health Care System

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NIA

Funeral
Director

5. Social Security Number

259-44-5978

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb 28, 1934

9. Birthplace (State or Foreign Country)

Ga.

Usual Residence of Decedent

10a. State

md

10b. County

NIA

10c. City, Town, or Location

Balto

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

5822 Winner Ave

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:
11/59 thru 1/12/62

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14or 5+)

12th

1 yr

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Chauffeur

18b. Kind of Business/Industry

Goodman, Cable + Guild Co.

17. Father's Name (First, Middle, Last)

Willie Carter Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Willie mae Revels

19a. Informant's Name/Relationship (Type, Print)

Angela Rogers-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 Thornhurst ct. Balto, md 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Jct

Date

8/5/96

20c. Location - City or Town, State

Owings Mills, md

21. Signature of Funeral Service Licensee

Bladys Wane

22. Name and Address of Facility

March F.H.-west
4300 Wabash Ave

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Septic Shock

Due to (or as a consequence of):

1 Week

b. Multiple Organ Failure

Due to (or as a consequence of):

1 Week

c. Necrotizing Fascitis

Due to (or as a consequence of):

2 Weeks

d. Gas Gangrene of Retroperitoneum

Due to (or as a consequence of):

3 Weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alejandro Rodriguez MD

29c. License number

1710163

29d. Date signed (Month, Day, Year)

8-1-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alejandro Rodriguez, M.D., 22 South Greene Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

AUG 05 1996

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6 + v a

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23015

ITEM#8 film g738 8/5/96ag perFH

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LARRY R. CLARY				2. Date of Death Month 8 Day 3 Year 96		3. Time of Death 1:30 a.m.		
	4a. Facility Name (If not institution, give street and number) BALTIMORE VA MEDICAL CENTER				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA		
Funeral Director	5. Social Security Number 218-44-3862		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 47 Yrs.		8. Date of Birth (Month, Day, Year) Aug 3 1946		
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County NA		10c. City, Town or Location Baltimore		
Usual Residence of Decedent		10d. Inside City Limits 1 Yes 2 No		10e. Street and Number 312 E. 23rd St.		10f. Zip Code 21218		10g. Citizen of What Country? USA	
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No vi Vietnam If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 3 yrs.		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Construction Co.					
17. Father's Name (First, Middle, Last) Willie Clary Sr.				18. Mother's Name (First, Middle, Maiden Surname) Pauline Prior					
19a. Informant's Name/Relationship (Type, Print) Willie Clary Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5362 Cordelia Ave Balto. Md. 21215					
20a. Method of Disposition 1 Burial 2 <input checked="" type="checkbox"/> Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		20c. Location - City or Town, State 8-3-96 Balto. Md					
21. Signature of Funeral Service Licensee Dennis B. Harris				22. Name and Address of Facility March Funeral Home - West 2380 Wabash Ave Balto Md. 21215					
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. sepsis Due to (or as a consequence of): b. AIDS Due to (or as a consequence of): c. fungemia Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 24 hours	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 Yes 2 <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
25. Was case referred to medical examiner? 1 Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier D Nazarian MD		29c. License number P8485		29d. Date signed (Month, Day, Year) 8/3/96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JEANETTE NAZARIAN, M.D. 22 S. GREENE ST. BALTIMORE, MD. 21201									
31. Date filed (Month, Day, Year) AUG 05 1996		32. Registrar's Signature Jeha Davidson-Rodriguez							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

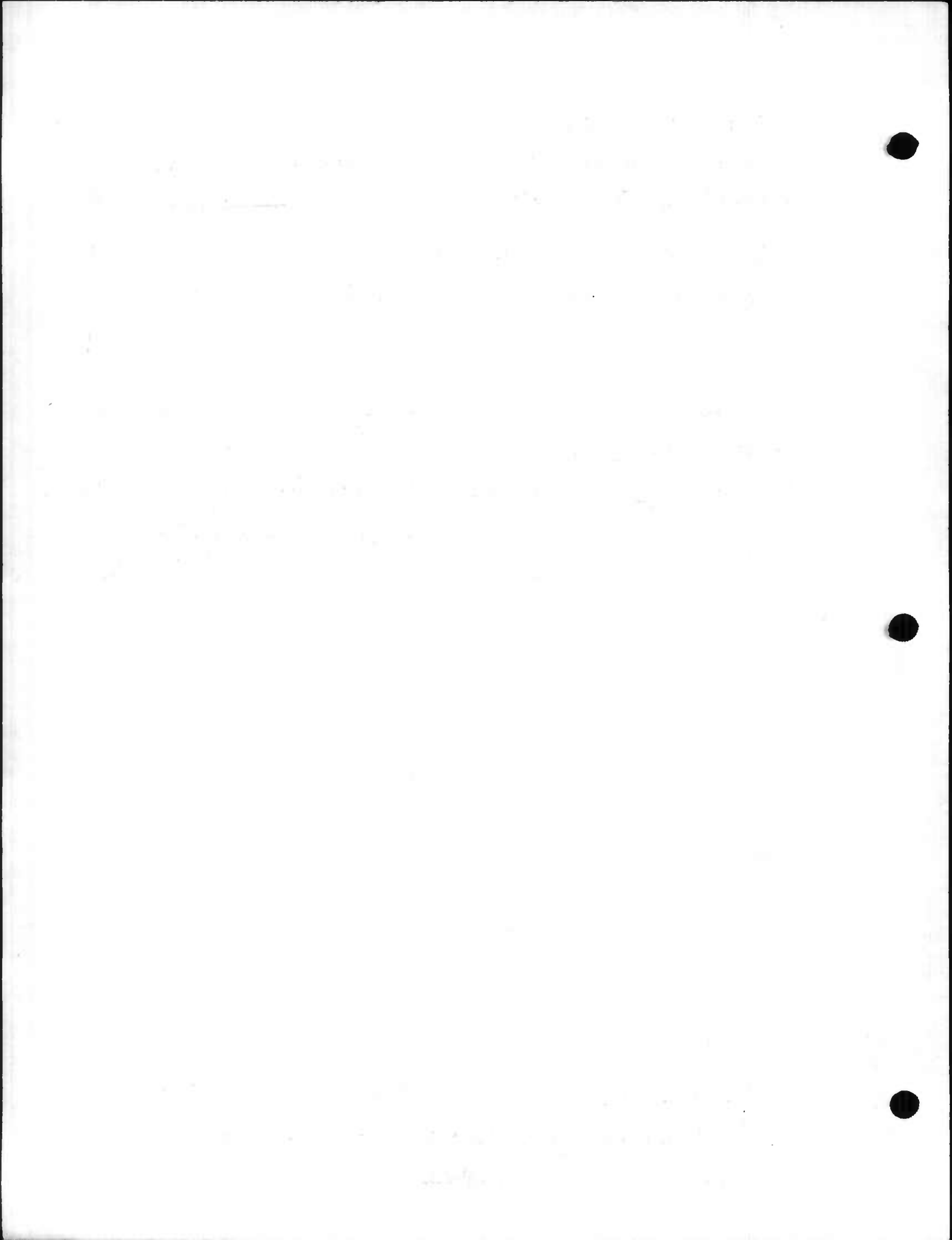
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

670A



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23016

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES William CRITZER				2. Date of Death Month Day Year AUGUST 1, 1996		3. Time of Death 9:15 a		
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A		
Funeral Director	5. Social Security Number 227 38 5551		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) 09 29 32		
	9. Birthplace (State or Foreign Country) Virginia		10a. State Md.		10b. County N/A		10c. City, Town or Location Baltimore		
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number 510 S. Washington Street				10f. Zip Code 21231		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korea		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance		16b. Kind of Business/Industry Apartment				
	17. Father's Name (First, Middle, Last) Thomas Spotswood Critzer				18. Mother's Name (First, Middle, Maiden Surname) Lula Ann Drummweller				
	19a. Informant's Name/Relationship (Type, Print) Alvin N. Critzer, Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 Linden Avenue Pasadena, Md. 21122				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory		Date 8-2-96		20c. Location - City or Town, State Baltimore, Md.		
	21. Signature of Funeral Service Licensee Charles S. Zeiler				22. Name and Address of Facility Charles S. Zeiler & Son Inc. 901 S. Conkling St. Balto., Md.				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Cause (Final disease or condition resulting in death) a. Pulmonary Hemorrhage Due to (or as a consequence of): b. Lung Cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Liver Failure Ischemic Cardiomyopathy							Approximate interval Between Onset and Death 1 week 2 months	
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Liver Failure Ischemic Cardiomyopathy							23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred							
28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier Robert J. [Signature]				29c. License number L8603		29d. Date signed (Month, Day, Year) August 1, 1996			
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Tower 110 Doctors Lounge 600 N. Wolfe St. Baltimore, MD 21205									
31. Date filed (Month, Day, Year) August 1, 1996		32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23017

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Isadore Coleman, Jr.				2. Date of Death Month July Day 31 Year 1996		3. Time of Death 12:45 pm		
	4a. Facility Name (If not institution, give street and number) # 7 Fennington Circle (res)				4b. City, Town, or Location of Death Reisterstown		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 216-54-5029		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 46 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 14, 1949	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
10a. State MD		10b. County Baltimore		10c. City, Town or Location Reisterstown			10d. Inside City Limits 1 Yes 2 No		
10e. Street and Number #7 Fennington Circle				10f. Zip Code 21117		10g. Citizen of What Country? USA			
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Correctional Officer		16b. Kind of Business/Industry Jail			
17. Father's Name (First, Middle, Last) Isadore Coleman, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Sarah Sheppard					
19a. Informant's Name/Relationship (Type, Print) Angela Coleman/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #7 Fennington Circle, Reisterstown, MD 21117					
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery		Date 8/3		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee Leroy O. Dyett			22. Name and Address of Facility LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO. 21207						
23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CANCER STOMACH Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death 2 1/2 yrs	
Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.								23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
								24a. Was an autopsy performed? 1 Yes 2 No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
25. Was case referred to medical examiner? 1 Yes 2 No			26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred			
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier [Signature]			29c. License number 035606		29d. Date signed (Month, Day, Year) 8/1/96	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Samuel Zyle, MD, 21 Crossroads Drive #45 Owings Mills, MD 21117									
31. Date filed (Month, Day, Year) AUG 05 1996			32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

AM ITEMS: 23 PART I, 27, 28a-f, PER State of Maryland / Department of Health and Mental Hygiene
 MEO FILM G-738 8/30/96 t.t

96 23018

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LAWRENCE OTTO CLUTTER				2. Date of Death Month Day Year JULY 28, 1996				3. Time of Death 19:13 P			
	4a. Facility Name (If not institution, give street and number) 724 S. CONKLING ST.				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A			
Funeral Director	5. Social Security Number 214 50 6386		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 48 Yrs.		8. Date of Birth (Month, Day, Year) 09 05 47		9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State Md.		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 724 South Conkling Street				10f. Zip Code 21224		10g. Citizen of What Country? USA					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Vietnam		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Musician			16b. Kind of Business/Industry Unknown				
	17. Father's Name (First, Middle, Last) Floyd Clutter				18. Mother's Name (First, Middle, Maiden Surname) Frances A. Unknown							
	19a. Informant's Name/Relationship (Type, Print) Deborah L. Clutter, Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 724 S. Conkling St. Balto., Md. 21224							
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory 8-1-96 Balto., Md.		20c. Location - City or Town, State					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Charles S. Zeiler & Son Inc. 6224 Easton Ave. Balto., Md.							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death) THIORIDAZINE INTOXICATION Due to (or as a consequence of): e. _____ Due to (or as a consequence of): f. _____ Due to (or as a consequence of): g. _____ Due to (or as a consequence of): h. _____											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
										24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
										24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 7/28/96		28b. Time of Injury 7:10 P M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred UNKNOWN				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME										
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number OCME		29d. Date signed (Month, Day, Year) JULY 29, 1996						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY ANN A. KOWALSKI 111 Penn Street, Baltimore, Maryland 21201												
31. Date filed (Month, Day, Year) AUG 05 1996										32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



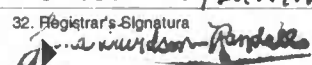
State of Maryland / Department of Health and Mental Hygiene

96 23019

ITEM#1 film g738 8/5/96ag perFH

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Florence L. CLAGETT				2. Date of Death Month 07 Day 29 Year 96		3. Time of Death 15:31	
	4a. Facility Name (If not institution, give street and number) University of Maryland Medical Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 213-12-4646		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 16, 1917	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Md.		10b. County Baltimore		10c. City, Town or Location Catonsville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 902 Marksworth Road				10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cashier				16b. Kind of Business/Industry Retail Business	
	17. Father's Name (First, Middle, Last) Harry C. Kratz				18. Mother's Name (First, Middle, Maiden Surname) Elsie Elizabeth Bond			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Woodrow H. Kratz (Brother)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14207 Quail Creek Way Sparks, Maryland 21152			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory Inc.		20c. Location - City or Town, State Beltsville, Maryland		20d. Date July 30, 1996	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue Catonsville, Maryland			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. myocardial infarction Due to (or as a consequence of): b. meningitis Due to (or as a consequence of): c. perforous bone defect Due to (or as a consequence of): d. seizure							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number P 08550		29d. Date signed (Month, Day, Year) 07/29/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gloria Yim 225. Greene St, Baltimore								
31. Date filed (Month, Day, Year) AUG 05 1996		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23020

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LEON PAUL CZARNECKI				2. Date of Death Month Day Year AUGUST 1 1996		3. Time of Death 4:45 am	
	4a. Facility Name (If not institution, give street and number) 7800 FLAGSTAFF ROAD				4b. City, Town, or Location of Death ROSEDALE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 218289036		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) MAY 4, 1931	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MO		10b. County BALTIMORE		10c. City, Town or Location ROSEDALE	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 7800 FLAGSTAFF ROAD		10f. Zip Code 21237		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: KOREA		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CALIBRATOR		16b. Kind of Business/Industry ELECTRICAL INSTR.			
	17. Father's Name (First, Middle, Last) LEONARD CZARNECKI				18. Mother's Name (First, Middle, Maiden Surname) MARY DOMBKOWSKA			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) CECILIA CZARNECKI / WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7800 FLAGSTAFF ROAD ROSEDALE, MD 21237			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SACRED HEART		20c. Location - City or Town, State 8/5/96 BALTIMORE, MD		20d. Date	
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE 21237			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. metastatic adenocarcinoma of lung Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Dua to (or as a consequence of): c. Dua to (or as a consequence of): d. 				Approximate Interval Between Onset and Death 1 YEAR			
State Registrar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
State Registrar	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
State Registrar	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D41406		29d. Date signed (Month, Day, Year) 8/2/96	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADHU CHAUDHRY FRANKLIN SQUARE HOSPITAL 9000 FRANKLIN SQUARE DRIVE BALTIMORE MD 21237							
	31. Date filed (Month, Day, Year) AUG 05 1996							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23021

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HAROLD CHICHESTER				2. Date of Death Month July Day 27 Year 1996		3. Time of Death 5:30 PM	
	4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL CENTER				4b. City, Town, or Location of Death RANDALLSTOWN		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 256-07-7547		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 99 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 13, 1897	
	9. Birthplace (State or Foreign Country) Connecticut							
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State MD		10b. County Carroll		10c. City, Town or Location Sykesville	
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 7200 Third Avenue		10f. Zip Code 21784		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced XX		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWI & WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer		16b. Kind of Business/Industry Engineering			
	17. Father's Name (First, Middle, Last) Allen Chichester		18. Mother's Name (First, Middle, Maiden Surname) Hattie Sturgess		19a. Informant's Name/Relationship (Type, Print) Mr. David Chichester (Son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 151 Baytree Drive, Destin, FL 32541	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation Serv.		Date 7/30/96		20c. Location - City or Town, State Hampstead, MD	
	21. Signature of Funeral Service Licensee Brian L. Haight		22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PNEUMONIA Due to (or as a consequence of):		Approximate Interval Between Onset and Death 5 DAYS	
	23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DEMENTIA HYPERTENSION		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
	28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier K.S. RAO M.D.		29c. License number D43462		
29d. Date signed (Month, Day, Year) JULY 27 1996		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K.S. RAO M.D. NORTHWEST HOSPITAL CENTER, RANDALLSTOWN MD		31. Date filed (Month, Day, Year) AUG 05 1996		32. Registrar's Signature Jake Davidson-Randall		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Mortuary Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23022

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Martin Duvall

2. Date of Death

Month August Day 3, Year 1996

3. Time of Death

6:10p.

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

219-12-9333

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) Dec. 27, 1907

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

201A Leppo Road

10f. Zip Code

21157

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collegia (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Maryland Ship Building

17. Father's Name (First, Middle, Last)

Marshall Duvall

18. Mother's Name (First, Middle, Maiden Summa)

Elsie Unknown

19a. Informant's Name/Relationship (Type, Print)

Louise Mazziott

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2310 Rockwell Ave. Catonsville, Md. 21228

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation Service

Data

8-5-96

20c. Location - City or Town, State

Hampstead Md.

21. Signature of Funeral Service Licensee

Harry W. Haight

22. Name and Address of Facility

Haight Funeral Home

P.O. Box 195 Sykesville, Md 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular accident

Due to (or as a consequence of):

b. Arterio sclerosis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. H. Ginsberg

29c. License number

D20964

29d. Date signed (Month, Day, Year)

August 5, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jerome H. Ginsberg, M.D. 8630 Liberty Plaza Mall Randallstown, MD 21133

State
Registrar

31. Date filed (Month, Day, Year)

AUG 05 1996

32. Registrar's Signature

J. Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23023

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Francis C. Evans

2. Date of Death

Month

Day

Year

Aug

1

96

3. Time of Death

7:25 AM

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

215-24-0743

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Oct. 7, 1929

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7317 Eden Brook Drive

10f. Zip Code

21046

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

None

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Giant Food Co.

17. Father's Name (First, Middle, Last)

Lawrence Evans

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Unkelbach

19a. Informant's Name/Relationship (Type, Print)

Rose Marie Evans (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7317 Eden Brook Drive, Columbia, MD 21046

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Columbia Mem. Park

Date

Aug.

5, 1996

20c. Location - City or Town, State

Clarksville, MD

21. Signature of Funeral Service Licensee

Robert H. H. H.

22. Name and Address of Facility

Witzke Funeral Homes, Inc.

5555 Twin Knolls Rd. Columbia, MD 21045

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. HYPERTENSIVE CARDIO MYOPATHY

Due to (or as a consequence of):

years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. Hypertensive

Due to (or as a consequence of):

years

c. Diabetes mellitus

Due to (or as a consequence of):

years

d. exogenous obesity

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lumbar spine Disease (ARTHRITIC)

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)4 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. John C. H. H.

29c. License number

MD 25210

29d. Date signed (Month, Day, Year)

8/11/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3460 Ellum Center Drive, Ellum City, MD

31. Date filed (Month, Day, Year)

AUG 05 1996

32. Registrar's Signature
John Davidson-RandallState
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours of death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23024
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy Lorraine Edenfield				2. Date of Death Month August Day 2 Year 1996		3. Time of Death 11:40 A.M.	
	4a. Facility Name (If not institution, give street and number) 2605 List Avenue				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 705-07-7839	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) October 10, 1917		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore, City			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 2605 List Ave..			10f. Zip Code 21214		10g. Citizen of What Country? United States		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dependent		16b. Kind of Business/Industry Never Worked			
17. Father's Name (First, Middle, Last) Charles H. Edenfield				18. Mother's Name (First, Middle, Maiden Surname) Julia Bris Moxley				
19a. Informant's Name/Relationship (Type, Print) Charles H. Edenfield, Sr. Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10e				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		Data 8/6/96		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE GASTROINTESTINAL BLEED Due to (or as a consequence of): b. POSSIBLE ACUTE GASTRIC ULCER. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIFFUSE DEGENERATIVE JOINT DISEASE						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D17148		29d. Date signed (Month, Day, Year) 8-2-96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Donato A. Vargas, Jr., M.D. 4706 Harford Road Baltimore, Md. 21214								
31. Date filed (Month, Day, Year) AUG 05 1996		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

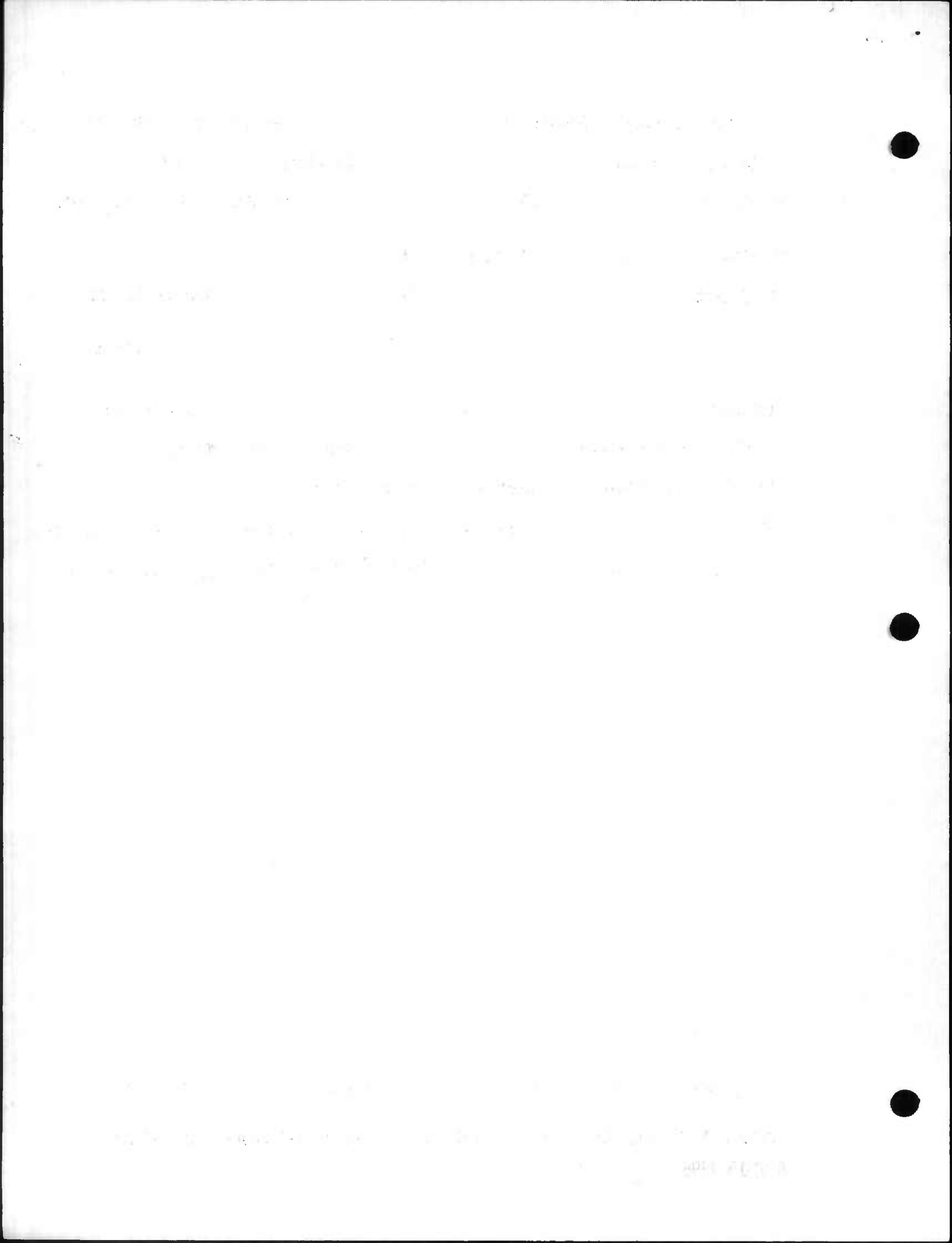
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23025

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph A Filipiak, Sr.

2. Date of Death

Aug 2 1996

3. Time of Death

5:00 PM

4a. Facility Name (If not institution, give street and number)

Harbor Hospital 3001 S. Hanover St. Baltimore City Baltimore

4b. City, Town, or Location of Death

4c. County of Death

Funeral
Director

5. Social Security Number

219-12-6898

6. Sex

☒ M ☐ F

7. Age (in yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

APR 30, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland Anne Arundel

10b. County

10c. City, Town or Location

Brooklyn Park

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

233 W. Arundel Road

10f. Zip Code

21225

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give
Year or Dates: WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Transfer Company

17. Father's Name (First, Middle, Last)

James Filipiak

18. Mother's Name (First, Middle, Maiden Surname)

Teny Sneder

19a. Informant's Name/Relationship (Type, Print)

Dorothy Regina Filipiak/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

233 W. Arundel Rd. Brooklyn Park, MD 21225

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory, Inc. 8/3/96

Data

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

George E. MacNabb

22. Name and Address of Facility

Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. metastatic small cell lung cancer unknown

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?
☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James Horodyski, M.D.

29c. License number

A52441616

29d. Date signed (Month, Day, Year)

8/2/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Horodyski, M.D. 3001 S. Hanover St, Baltimore, MD 21225

31. Date filed (Month, Day, Year)

AUG 05 1996

32. Registrar's Signature

John Anderson

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report is a general
introduction to the subject of the study.
It is a very important part of the report.

2. The second part of the report is a
detailed description of the methods used in the study.
It is a very important part of the report.

3. The third part of the report is a
detailed description of the results of the study.
It is a very important part of the report.

4. The fourth part of the report is a
detailed description of the conclusions of the study.
It is a very important part of the report.

5. The fifth part of the report is a
detailed description of the recommendations of the study.
It is a very important part of the report.

6. The sixth part of the report is a
detailed description of the bibliography of the study.
It is a very important part of the report.

7. The seventh part of the report is a
detailed description of the appendix of the study.
It is a very important part of the report.

8. The eighth part of the report is a
detailed description of the index of the study.
It is a very important part of the report.

9. The ninth part of the report is a
detailed description of the cover of the study.
It is a very important part of the report.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

10-4-96 eoh
ITEMS: 23, 29 dper DR. G740

State of Maryland / Department of Health and Mental Hygiene

96 23026

Item 18, film g739, 9-27-96, dk

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MATTHEW FONTANA				2. Date of Death Month Day Year JUL 28 1996		3. Time of Death 0620		
	4a. Facility Name (If not institution, give street and number) HOWARD COUNTY GENERAL HOSPITAL				4b. City, Town, or Location of Death COLUMBIA		4c. County of Death HOWARD		
Funeral Director	5. Social Security Number N/A	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUL 27 1996		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County Howard	10c. City, Town or Location Ellicott City			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 3373 Oak West Drive			10f. Zip Code 21043		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A		College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A		16b. Kind of Business/Industry N/A		
	17. Father's Name (First, Middle, Last) David Vincent Fontana				18. Mother's Name (First, Middle, Maiden Surname) Schmidt Christine Marie Schmidt				
	19a. Informant's Name/Relationship (Type, Print) David Vincent Fontana (Father)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3373 Oak West Drive Ellicott City, Maryland 21043				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Columbia Memorial Park		Date August 3, 1996		20c. Location - City or Town, State Columbia, Maryland		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, Maryland 21228				
	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) e. SEVERE RESPIRATORY DISTRESS SYNDROME Due to (or as a consequence of): b. PREMATURITY Due to (or as a consequence of): c. SEPSIS Due to (or as a consequence of): d. SEVERE METABOLIC ACIDOSIS								16 HOURS 54 MIN 16 HOURS 54 MIN 16 HOURS 54 MIN 4 HOURS
Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24e. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 		29c. License number D 39613		29d. Date signed (Month, Day, Year) JUL 29, 1996 10-2-96					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) NIKHILKUMAR C. RAVAL, M.D.		SCN, HOWARD COUNTY GENERAL HOSPITAL 5755, CEDARLANE, COLUMBIA, MD 21044							
31. Date filed (Month, Day, Year) AUG 05 1996									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23027

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>LILLIAN C. FISH</i>				2. Date of Death Month <i>August</i> Day <i>4</i> Year <i>1996</i>		3. Time of Death <i>8:45pm</i>	
	4e. Facility Name (If not institution, give street and number) <i>SYKESVILLE ELDERCARE</i>				4b. City, Town, or Location of Death <i>SYKESVILLE</i>		4c. County of Death <i>CARROLL</i>	
Funeral Director	5. Social Security Number <i>215-46-9262</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>91</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>JAN. 21, 1905</i>	9. Birthplace (State or Foreign Country) <i>MARYLAND</i>
	Usual Residence of Decedent				10c. City, Town or Location <i>BALTIMORE</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. State <i>MARYLAND</i>		10b. County <i>N/A</i>		10f. Zip Code <i>21223</i>		10g. Citizen of What Country? <i>U.S.A.</i>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>WHITE</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>HOMEMAKER</i>		16b. Kind of Business/Industry <i>OWN HOME</i>				
17. Father's Name (First, Middle, Last) <i>WILLIAM S. WEGWERTH</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>MARGARET A. SCHAEFER</i>						
19a. Informant's Name/Relationship (Type, Print) <i>SAMUEL E. FISH / SON</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>111 WYNDCREST AVENUE, CATONSVILLE, MARYLAND 21228</i>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>LOUDON PARK CEMETERY</i>		Date <i>AUG 8, 1996</i>		20c. Location - City or Town, State <i>BALTIMORE, MARYLAND</i>		
21. Signature of Funeral Service Licensee <i>Sam C. Lewis</i>		22. Name and Address of Facility <i>LOUDON PARK FUNERAL HOME 3620 WILKENS AVENUE, BALTIMORE, MARYLAND 21229</i>						
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>CEREBROVASCULAR ACCIDENT</i> Due to (or as a consequence of): <i>GENERALIZED ARTERIOSCLEROSIS</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <i>DEHYDRATION</i> <i>CORONARY ARTERY DISEASE</i>						Approximate Interval Between Onset and Death <i>1 day</i> <i>30 years</i>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>DEHYDRATION</i> <i>CORONARY ARTERY DISEASE</i>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29f. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29g. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier <i>John M.D.</i>		29c. License number <i>D-22609</i>		29d. Date signed (Month, Day, Year) <i>AUGUST 5-1996</i>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>RUBEN REIDER M.D. 7445 FURNACE BRANCH RD Glen Burnie MD 21060</i>								
31. Date filed (Month, Day, Year) <i>AUG 05 1996</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23028

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LEWIS M. GARMIZE				2. Date of Death Month July Day 31 Year 1996		3. Time of Death 6pm													
	4a. Facility Name (If not institution, give street and number) Howard Cty Gen. Hosp				4b. City, Town, or Location of Death Columbia		4c. County of Death Howard													
Funeral Director	5. Social Security Number 221-20-4546		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 12, 1931	9. Birthplace (State or Foreign Country) NY												
	Usual Residence of Decedent																			
To Be Completed by Funeral Director	10a. State MD		10b. County Howard		10c. City, Town or Location Columbia		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
	10e. Street and Number 5226 Paul Revere Ride				10f. Zip Code 21044		10g. Citizen of What Country? USA													
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White													
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Psychologist		16b. Kind of Business/Industry Great Oaks Center State of MD													
	17. Father's Name (First, Middle, Last) Maurice M. Garmize				18. Mother's Name (First, Middle, Maiden Surname) Matilda Fink															
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Stephen M. Garmize (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5226 Paul Revere Ride, Columbia, MD 21044															
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sunnyridge Mem. Park		20c. Date Aug. 6, 1996		20d. Location - City or Town, State Crisfield, MD													
	21. Signature of Funeral Service Licensee Robert Gregory Buhner				22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd. Columbia, MD 21045															
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Lung Cancer</td> <td>Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death 6 months</td> </tr> <tr> <td>b. Brain Metastasis</td> <td>Due to (or as a consequence of):</td> <td>4 weeks</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Lung Cancer	Due to (or as a consequence of):	Approximate Interval Between Onset and Death 6 months	b. Brain Metastasis	Due to (or as a consequence of):	4 weeks	c.	Due to (or as a consequence of):		d.	Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. Lung Cancer	Due to (or as a consequence of):	Approximate Interval Between Onset and Death 6 months																	
	b. Brain Metastasis	Due to (or as a consequence of):	4 weeks																	
	c.	Due to (or as a consequence of):																		
	d.	Due to (or as a consequence of):																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown														
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
		28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)														
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Nicholas Koutroubalos MD		29c. License number D38509		29d. Date signed (Month, Day, Year) July 31 1996														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NICHOLAS KOUTROUBALOS 4045 LITTLERIDGE PARK COLUMBIA MD 21044																				
31. Date filed (Month, Day, Year) AUG 05 1996																				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23029

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ARDELLA E. GALTMORE				2. Date of Death Month August Day 01 Year 96		3. Time of Death 11:30 AM	
	4a. Facility Name (If not institution, give street and number) Liberty Medical Center				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funeral Director	5. Social Security Number 21516 7530		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Year 5-1-10	9. Birthplace (State or Foreign Country) COVINGTON, VA.
	Usual Residence of Decedent				10a. State MARYLAND		10b. County BALTIMORE	
To Be Completed by Funeral Director	10c. City, Town or Location BALTIMORE				10d. Inade City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 4017 LIBERTY HTS. AVE.	
	10f. Zip Code 21215				10g. Citizen of What Country? U.S.A.		10h. Inade City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE		16b. Kind of Business/Industry			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) JAMES R. GALTMORE				18. Mother's Name (First, Middle, Maiden Surname) CORNELIA ANDERSON			
	19a. Informant's Name/Relationship (Type, Print) MANIE P. GALTMORE Sister-LAB				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3503 CALLAWAY AVE. BALD. MD. 21215			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PARK		20c. Date 8-9-96		20d. Location - City or Town, State BALTIMORE, MD 21244	
	21. Signature of Funeral Service Licensee Cynthia Galtmore		22. Name and Address of Facility 1807 MCKEAN AVE. BALTIMORE, MD 21217					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aspiration PNEUMONIA Due to (or as a consequence of): SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last SEP SIS Due to (or as a consequence of): Aspiration PNEUMONIA							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier Kwang N. Kim				29c. License number D17031		29d. Date signed (Month, Day, Year) 08/01/96	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) KWANG N. KIM, M.D. 2600 Liberty Height, Baltimore, 21215							
State Registrar	31. Date filed (Month, Day, Year) AUG 05 1996				32. Registered Signature Julia Davidson-Randall			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23030

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET W GODWIN

2. Date of Death

Month

Day

Year

3. Time of Death

6:05 AM

4a. Facility Name (If not institution, give street and number)

CARROLL COUNTY HOSPITAL

4b. City, Town, or Location of Death

WESTMINSTER

4c. County of Death

CARROLL

Funeral
Director

5. Social Security Number

108-18-2095

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

05-21-1917

9. Birthplace (State or Foreign Country)

DELAWARE

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CARROLL

10c. City, Town or Location

WESTMINSTER

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

200 ST. LUKES CIRCLE LUTHERAN VILLAGE

10f. Zip Code

21158

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

REGISTER NURSE

16b. Kind of Business/Industry

NURSING

17. Father's Name (First, Middle, Last)

JOHN WHALEY

18. Mother's Name (First, Middle, Maiden Surname)

EMMA S. HUDSON

19a. Informant's Name/Relationship (Type, Print)

WILLIAM J. GODWIN JR. (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1925 BETHEL ROAD, FINKSBURG, MARYLAND 21048

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BARRETT'S CHAPEL

Date

7/20/1996 FREDERICA, DELAWARE

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Thomas R. Trader

22. Name and Address of Facility

TRADER FUNERAL HOME INC.

12 LOTUS ST. DOVER, DELAWARE 19901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPTIC SHOCK.

Due to (or as a consequence of):

b. Cholangitis, acute calculous

Due to (or as a consequence of):

c. Cholecystitis, acute

Due to (or as a consequence of):

d. Deep Venous Thrombosis, leg

Approximate Interval Between Onset and Death

7 days

7 days

7 days

7 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Actual Hemorrhage

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Frederick M.D.

29c. License number

D38915

29d. Date signed (Month, Day, Year)

7/17/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

FREISI

245 Stoner

Westminster MD.

31. Date filed (Month, Day, Year)

JUL 26 1996

32. Registrar's Signature

Julia Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten text at the top of the page, possibly a header or title.

Second line of handwritten text, continuing the narrative or list.

Third line of handwritten text, appearing as a separate entry or section.

Fourth line of handwritten text, showing more detail or continuation.

Fifth line of handwritten text, possibly a transition or new point.

Sixth line of handwritten text, continuing the flow of information.

Seventh line of handwritten text, showing a change in subject or detail.

Eighth line of handwritten text, appearing as a concluding statement or list item.

Ninth line of handwritten text at the bottom of the page.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23031

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Martha

Gary

2. Date of Death

Month

Day

Year

August

1,

1996

3. Time of Death

7:55 am

4a. Facility Name (If not institution, give street and number)

Sandtown-Winchester Nursing Hm

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

5. Social Security Number

096-34-4598

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan. 16, 1943

9. Birthplace (State or Foreign Country)

NY

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1105 N. Fulton Ave.

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housekeeping

16b. Kind of Business/Industry

Office Building

17. Father's Name (First, Middle, Last)

Murray

Brown

18. Mother's Name (First, Middle, Maiden Surname)

Kellie

Brown

19e. Informant's Name/Relationship (Type, Print)

Alicia Gary/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1105 N. Fulton Ave. Balto., MD 21217

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory

Date

8/6

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee

James A. Morton

22. Name and Address of Facility

James A. Morton & Sons Funeral Home
1701 Laurens St. Balto., MD 2121723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Carcinoma of lung with brain metas 1 yr.

Due to (or as a consequence of):

b. Seizure disorder 2 months

Due to (or as a consequence of):

c. Renal Insufficiency 2 week

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Amatun H Naem M.D.

29c. License number

D15503

29d. Date signed (Month, Day, Year)

AUG 2 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

AMATUN H NAEM, 501 Dolphin Street, Baltimore, MD 21217

31. Date filed (Month, Day, Year)

AUG 05 1996

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

the hospital or attending physician: The law requires that the death certificate be executed
within 24 hours after death.
To be signed by the attending physician and
to be signed by the funeral director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

THE UNIVERSITY OF CHICAGO
DIVISION OF THE PHYSICAL SCIENCES

DEPARTMENT OF PHYSICS
5301 S. DICKINSON AVE.
CHICAGO, ILL. 60637

TEL: 773-936-3700
FAX: 773-936-3701
WWW.PHYSICS.UCHICAGO.EDU

ADMISSIONS OFFICE
5301 S. DICKINSON AVE.
CHICAGO, ILL. 60637

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5301 S. DICKINSON AVE.
CHICAGO, ILL. 60637

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State of Maryland / Department of Health and Mental Hygiene

96 23032

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Francis Howard HEUSLER				2. Date of Death Month Day Year August 1, 1996		3. Time of Death 12:20 PM	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital				4b. City, Town, or Location of Death Rossville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 217-24-8319		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) March 4, 1930	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk	
To Be Completed by Funeral Director	10d. Inside City Limits 1 Yes 2 No		10e. Street and Number 400 Trappe Road		10f. Zip Code 21222		10g. Citizen of What Country? United States	
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 Yes 2 No		14. Race - American Indian, Black, White, etc. White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Warehouse		16b. Kind of Business/Industry Communications			
	17. Father's Name (First, Middle, Last) Not Known				18. Mother's Name (First, Middle, Maiden Summa) Not Known			
	19a. Informant's Name/Relationship (Type, Print) Mrs. Lois I. Heusler/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 Trappe Road Dundalk, Maryland 21222			
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		20c. Date 8/5/1996		20d. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metabolic acidosis Due to (or as a consequence of): b. Shock Due to (or as a consequence of): c. Aspiration pneumonia Due to (or as a consequence of): d.							
	23b. Approximate Interval Between Onset and Death 8 hours							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown								
24a. Was an autopsy performed? 1 Yes 2 No								
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 				29c. License number D21846		29d. Date signed (Month, Day, Year) 8/1/96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Martin Sheridan 9101 Franklin Square Dr. Baltimore, Maryland 21237							
	31. Date filed (Month, Day, Year) AUG 05 1996							
	32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

96 23033

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DALLAS ROBERT HAWKINS			2. Date of Death Month Day Year July 31 1996		3. Time of Death 09:55 p.m.		
	4e. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL			4b. City, Town, or Location of Death BALTIMORE		4c. County of Death n/a		
Funeral Director	5. Social Security Number 216-03-7002		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) FEB. 8, 1911	
	9. Birthplace (State or Foreign Country) BALTIMORE, MD							
To Be Completed by Funeral Director	Usual Residence of Decedent			10e. State MD			10b. County n/a	
	10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number 3064 ASCENSION STREET			10f. Zip Code 21225			10g. Citizen of What Country? UNITED STATES	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: unk.		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DRIVER- TRANSPORTATION		16b. Kind of Business/Industry EDGEWOOD ARSENAL			
	17. Father's Name (First, Middle, Last) JOHN HAWKINS			18. Mother's Name (First, Middle, Maiden Surname) MARGARET BERRY				
	19a. Informant's Name/Relationship (Type, Print) SAMUEL DUTTON			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1419 STONEWOOD ROAD, BALTIMORE, MD 21239				
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON F OREST VA CEM.		20c. Location - City or Town, State 8-5 OWINGS MILLS, MD			
	21. Signature of Funeral Service Licensee J. Valencia Holland			22. Name and Address of Facility WM. C. MARCHFH.-1101 E. NORTH AVENUE				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e. HYPERKALEMIA Due to (or as a consequence of):							1 hr	
{ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Bilateral Lower Extremity Ischemia. Due to (or as a consequence of):							4 days	
c. Bilateral Femoral artery occlusion. Due to (or as a consequence of):							4 days	
d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End Stage Renal disease							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier M.A. Fayilan MD			29c. License number P09312			29d. Date signed (Month, Day, Year) July 31st, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Muhammad ZAYDAN, M.D. - Good Samaritan Hospital.								
31. Date filed (Month, Day, Year) AUG 05 1996		32. Registrar's Signature J. Valencia Holland						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

Leave Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23034

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Yvonne E. Harris				2. Date of Death Month Day Year Aug 02 1996		3. Time of Death *8:00 A.M.		
	4a. Facility Name (If not institution, give street and number) 317 E. North Ave Apt #107				4b. City, Town, or Location of Death Baltimore		4c. County of Death None		
Funeral Director	5. Social Security Number 218-64-5684	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 41 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan 15, 1955		9. Birthplace (State or Foreign Country) Md	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Md	10b. County None	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 317 E. North Ave Apt 107				10f. Zip Code 21202		10g. Citizen of What Country? Usa		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook			16b. Kind of Business/Industry Unknown			
	17. Father's Name (First, Middle, Last) Rudolph Williams				18. Mother's Name (First, Middle, Maiden Surname) Mary E. Singletary				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Margaret Foster (Sister)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2849 Edgcombe Circle South Balto., Md. 21215				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion		Date 8/6/96		20c. Location - City or Town, State Landsdowne, Maryland		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility The Derrick C. Jones Funeral Home 4611 Park Heights Ave.				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory Failure Due to (or as a consequence of): Acquired Immune Deficiency Syndrome Due to (or as a consequence of): Heroin Abuse Due to (or as a consequence of): BLINDNESS, BILATERAL							Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number 237299		29d. Date signed (Month, Day, Year) 8/3/96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. CARLOS PAGE, 317 E. North Ave, Apt 107, Baltimore, MD 21202									
31. Date filed (Month, Day, Year) AUG 05 1996									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

96 23035

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LORRAINE HEMPFIELD				2. Date of Death Month JULY Day 30, Year 1996				3. Time of Death 5:23 PM	
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY				4c. County of Death N/A	
Funeral Director	5. Social Security Number 217-46-6112		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 43 Yrs.		8. Date of Birth Month, Day, Year JUN 16, 1953		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent				10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10e. Street and Number 2625 E. MONUMENT ST.				10f. Zip Code 21205		10g. Citizen of What Country? U.S.A			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (14or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CLERICAL		16b. Kind of Business/Industry OFFICE			
	17. Father's Name (First, Middle, Last) LEROY ROGERS				18. Mother's Name (First, Middle, Maiden Surname) Helen Crocker					
	19a. Informant's Name/Relationship (Type, Print) TIA ROGERS				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2625 E. MONUMENT ST. BALTIMORE, MD 21205					
	20a. Manner of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL, 8/6/96, BALTIMORE, MD		20c. Location - City or Town, State BALTIMORE, MD					
	21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility GARY T. MARCH FUNERAL HOME P.A. 270 FREDERICK PASS BALTIMORE, MD 21229					
	23a. Part I. Under the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) BRAIN HERNIATION									
	23b. Part II. Under the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last INTRACEREBRAL HEMORRHAGE									
	Physician /Medical Examiner	23c. Part III. Under the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. HYPERTENSION								
23d. Part IV. Under the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 12 HOURS										
24. Part V. Under the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier [Signature]				29c. License number D 2605	
	29d. Data signed (Month, Day, Year) July 30th, 1996									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADNAN I. QURESHI MD, 600 WOLFE STREET, BALTIMORE, MD 21287									
State Registrar	31. Date filed (Month, Day, Year) AUG 05 1996				32. Registrar's Signature Julia Davidson-Randall					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

96-4299-510

B.K.S ITEMS: 23 PART I, 27, 28a-f
 PER MED FILM g-738 8/15/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23036

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CARLOS JOHNSON		2. Date of Death Month JULY Day 31 , Year 1996		3. Time of Death 1215 PM
	4a. Facility Name (If not institution, give street and number) 2722 REISTERSTOWN ROAD APT-#2		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
Funeral Director	5. Social Security Number 213-78-2756	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 36 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) June 15, 1960		9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State MD		10b. County N/A
	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 2227 Reisterstown Road		10f. Zip Code 21215		10g. Citizen of What Country? USA
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) College		
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Driver		16b. Kind of Business/Industry Liquor Distributor		
	17. Father's Name (First, Middle, Last) Carlos Johnson, Sr.		18. Mother's Name (First, Middle, Maiden Surname) Margie Rosborough		
	19a. Informant's Name/Relationship (Type, Print) Carlos Johnson, Sr.		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6857 Queensferry Rd, Towson, MD 21229 Apt. 1B		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Vet. Cem.		20c. Location - City or Town, State Owings Mills, MD
	21. Signature of Funeral Service Licensee <i>Leroy O. Dyett</i>		22. Name and Address of Facility LERROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO. 21207		
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MARCOTIC INTOXICATION a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year) FOUND 7-31-96					
28b. Time of Injury UNKNOWN M					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how Injury occurred UNKNOWN					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME					
28f. Location (Street and Number or Rural Route Number, City or Town, State) 2722 REISTERSTOWN RD. BALTIMORE, MD.					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>John Locke</i>					
29c. License number O.C.M.E					
29d. Date signed (Month, Day, Year) AUG. 01, 1996					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) AUG 05 1996					
32. Registrar's Signature <i>Wilson-Rendell</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23037

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LAURA M JAASKELA

2. Date of Death

Aug

Day

Year

3. Time of Death

12⁰⁰ p.m.Funeral
Director

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

001-14-7210

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

SEPT 18, 1922

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

New Hampshire

10b. County

Cheshire

10c. City, Town or Location

Jaffrey

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

28-A River Street

10f. Zip Code

03452

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Sales Manager

16b. Kind of Business/Industry

Match Book
Manufacturer

17. Father's Name (First, Middle, Last)

Peter Jaaskela

18. Mother's Name (First, Middle, Maiden Surname)

Edith Leinonen

19a. Informant's Name/Relationship (Type, Print)

Eila J. Everts/sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

416 Oak Court Catonsville, MD 21228

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory, Inc. 8/5/96

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

George E. MacNabb

22. Name and Address of Facility

Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

METASTATIC MIXED MULLERIAN CANCER

Immediate Cause (Final
disease or condition
resulting in death)

a. WITH RHABDOMYOSARCOMA

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

ONE YEAR

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CARCINOMA OF THE BREAST

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

F. Ansah

29c. License number

PO 9519

29d. Date signed (Month, Day, Year)

AUGUST 03, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

FRANCIS ANSAH, MD
900 CATON AVE. ST AGNES HOSPITAL, BALTIMORE, MD 21229

31. Date filed (Month, Day, Year)

AUG 05 1996

32. Registrar's Signature

John Anderson-Rendell

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

ITEM#12 g738 8/14/96ag perFH
ITEM10b g738 8/14/96ag perFH

State of Maryland / Department of Health and Mental Hygiene

96 23038

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM JOSEPH KARNs				2. Date of Death Month AUG , Day 03 , Year 1996		3. Time of Death 10:31 AM	
	4e. Facility Name (If not institution, give street and number) GREATER LAUREL HOSPITAL				4b. City, Town, or Location of Death LAUREL		4c. County of Death PRINCE GEORGE	
Funeral Director	5. Social Security Number 213-36-3008		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) MARCH 23, 1939	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) MARYLAND		10. State MD		10b. County HOWARD	
To Be Completed by Funeral Director	10a. State MD				10b. County HOWARD		10c. City, Town or Location MT. AIRY	
	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 6649 CHRISTY ACRE CIRCLE		10f. Zip Code 21771	
To Be Completed by Physician/Medical Examiner	10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4 YRS	
To Be Completed by Physician/Medical Examiner	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) INSURANCE AGENT				16b. Kind of Business/Industry INSURANCE		17. Father's Name (First, Middle, Last) JOHN DAVIDSON KARNs	
	18. Mother's Name (First, Middle, Maiden Surname) BARBARA HELEN WAGENER				19a. Informant's Name/Relationship (Type, Print) JOYCE J. KARNs (WIFE)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6649 CHRISTY ACRE CIRCLE - MT. AIRY, MD 21771	
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PK		20c. Location - City or Town, State 8/7/96 ELKCRIDGE	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Arteriosclerotic Cardiovascular Disease	
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) AUG. 04, 1996	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Donald G. Wright M.D. 111 Penn Street, Baltimore, Maryland 21201				31. Date filed (Month, Day, Year) AUG 05 1996		32. Registrar's Signature 	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 24e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. The first part of the report is a general
description of the area and the people who live there.

2. The second part is a description of the
climate and the weather.

3. The third part is a description of the
economy and the way of life.

4. The fourth part is a description of the
education and the health services.
5. The fifth part is a description of the
culture and the traditions.
6. The sixth part is a description of the
history and the development.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23039

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY ESTELLE KIRSTUKAS						2. Date of Death Month Aug Day 02 Year 1996		3. Time of Death 10:04 AM	
	4a. Facility Name (If not institution, give street and number) ST. AGNES HOSPITAL						4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 218-12-6115		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) MAY 8, 1923		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 5119 WESTLAND BOULEVARD				10f. Zip Code 21227		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) 10TH GRADE		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry HOMEMAKING					
	17. Father's Name (First, Middle, Last) MAURICE GORMAN						18. Mother's Name (First, Middle, Maiden Surname) MYRTLE KAUFMAN			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) BERNARD KIRSTUKAS (HUSBAND)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5119 WESTLAND BOULEVARD-BALTIMORE, MD 21227					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PARK		Data 8/6/96		20c. Location - City or Town, State ELKRIDGE			
	21. Signature of Funeral Service Licensee <i>M. Leaf Coleman</i>				22. Name and Address of Facility HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229					
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. exsanguination Due to (or as a consequence of): b. Dissiminated Intravascular coagulation Due to (or as a consequence of): c. Abdominal Aortic Aneurysm rupture Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 6 hr. 6 hr 11 hrs									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Past MI. Rheumatoid Arthritis on steroids									
State Registrar	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>John S. ... M.D.</i>		29c. License number 2050		29d. Date signed (Month, Day, Year) 08/02/96			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUMDEEP SINGH, M.D. DEPT. OF SURG. ST AGNES HOSPITAL, MD 21229									
	31. Date filed (Month, Day, Year) AUG 05 1996									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23040

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Lewis				2. Date of Death Month Day Year July 18, 1996		3. Time of Death 8:08 a.m.	
	4a. Facility Name (If not Institution, give street and number) 4323 Loch Raven Boulevard				4b. City, Town, or Location of Death Baltimore		4c. County of Death n/a	
Funeral Director	5. Social Security Number 218-28-3053		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) May 6, 1932	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County n/a		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 4323 Loch Raven Boulevard		10f. Zip Code 21239		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown		16b. Kind of Business/Industry unknown				
17. Father's Name (First, Middle, Last) unknown		18. Mother's Name (First, Middle, Maiden Surname) unknown		19a. Informant's Name/Relationship (Type, Print) Edda Lane/Care Provider		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4323 Loch Raven Boulevard-Baltimore, MD. 21239		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) State rem.		20b. Place of Disposition (Name of cemetery, crematory or other place) in		20c. Location - City or Town, State Date				
21. Signature of Funeral Service Licensee Ronald S. Wade, D.C.		22. Name and Address of Facility State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Coronary artery disease Due to (or as a consequence of): b. Smoking & hypercholesterolemia Due to (or as a consequence of): c. hypercholesterolemia Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death Indefinite Indefinite		
23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chronic Obstructive Pulmonary Disease Myocardial infarction x 2 (3/93 & 4/94) Schizophrenia		23c. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? N/A <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Susan Henley MD		29c. License number D43591		29d. Date signed (Month, Day, Year) 7/26/96		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Susan Henley MD Belair Road Family Health Center 21213		31. Date filed (Month, Day, Year) AUG 05 1996		32. Registrar's Signature Julia Davidson				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Dorothy Virginia McCready				2. DATE OF DEATH MONTH DAY YEAR August 02, 1996		3. TIME OF DEATH 7:50 A.M. M	
4. SOCIAL SECURITY NUMBER 216-48-7233		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH MONTH DAY YEAR 08/24/1907	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) 4307 Washington Way		9b. CITY, TOWN OR LOCATION OF DEATH Sykesville	
9c. COUNTY OF DEATH Carroll				10a. STATE Maryland		10b. COUNTY Carroll	
10c. CITY, TOWN OR LOCATION Sykesville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 4307 Washington Way	
10f. ZIP CODE 21784		10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Domestic			
17. FATHER'S NAME (First, Middle, Last) Thomas W. Davis				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillie R. Tilton			
19a. INFORMANT'S NAME (Type/Print) Charles McCready Jr. Grandson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4307 Washington Way Sykesville, Md 21784			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Cemetery		DATE 8/5		20c. LOCATION — City or Town, State Baltimore, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kathleen Weber CFSP</i>				22. NAME AND ADDRESS OF FACILITY David J. Weber F.H. 5311 Edmondson Ave. Baltimore, Md 21229			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Possible Lung Cancer with Empyema</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Gravely Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Coronary Artery Disease</i> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 2-3 weeks 6-8 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes Mellitus</i> <i>etc.</i>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ardena H. H. H. H. H.</i>				29c. LICENSE NUMBER D04832		29d. DATE SIGNED (Month, Day, Year) August 2, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROLEN M. SPONDANO, MD 405 Frederick Road, Suite 162 Catonville, MD 21228							
31. DATE FILED (Month, Day, Year) AUG 05 1996		32. REGISTRAR'S SIGNATURE <i>John J. H. H. H.</i>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23042

ITEM#26 film g738 8/5/96ag perFacilityCertificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Agnes Virginia Miller

2. Date of Death

Month Day Year
July 27, 1996

3. Time of Death

6:15 PM

4a. Facility Name (If not institution, give street and number)

5390 King Arthur Circle

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

224-12-1108

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Dec. 3, 1911

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State
Maryland

10b. County

Baltimore

10c. City, Town or Location

Rosedale

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5390 King Arthur Circle

10f. Zip Code

21237

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

3 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Presser

16b. Kind of Business/Industry

Dry Cleaning

17. Father's Name (First, Middle, Last)

George W. Hott

18. Mother's Name (First, Middle, Maiden Surname)

Clersa S. Loy

19a. Informant's Name/Relationship (Type, Print)

Brenda A. Nave (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5390 King Arthur Circle Rosedale, Maryland 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery 7/30/1996

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Carcinomatosis

Due to (or as a consequence of):

b.

Cause of the Pecun.

Due to (or as a consequence of):

c.

Cause of edon

Due to (or as a consequence of):

d.

Cause of Cerebr.

Approximate Interval Between Onset and Death

~ 2 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

29c. License number

D25902

29d. Date signed (Month, Day, Year)

07-29-96

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Efem E. Imoke, MD 4713 Leeds Ave. Balto. MD 21227

31. Date filed (Month, Day, Year)

AUG 05 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23043

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Verna Elizabeth Messick

2. Date of Death

Month

Day

Year

August 3, 1996

3. Time of Death

6:50 p.m.

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

409-08-9057

6. Sex

1 ☐ M2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

November 1, 1910

9. Birthplace (State or Foreign Country)

Tennessee

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

200 Enfield Road

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Rainey

18. Mother's Name (First, Middle, Maiden Surname)

Emma Taylor

19a. Informant's Name/Relationship (Type, Print)

Verna Bazzell

DTR

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

200 Enfield Road Baltimore, Maryland 21212

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rainey Cemetery

Date

8/7/96

20c. Location - City or Town, State

Linden Tennessee

21. Signature of Funeral Service Licensee

Bennis Stephen Kenakis

22. Name and Address of Facility

Mitchell-Wiedefeld Home
6500 York Road Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

b. Diabetes Mellitus

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 days

15 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

JH MD

29c. License number

D34652

29d. Date signed (Month, Day, Year)

August 4, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J HASWELL 2 NORTH AVE. BEL AIR, MARYLAND 21014

31. Date filed (Month, Day, Year)

AUG 05 1996

32. Registrar's Signature

Julia R. [Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23044

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James F. Mixter				2. Date of Death Month Day Year Aug 1, 1996				3. Time of Death 4:54 pm						
	4a. Facility Name (If not institution, give street and number) 23 Bon Bon Court				4b. City, Town, or Location of Death Reisterstown				4c. County of Death Baltimore Co						
Funeral Director	5. Social Security Number 213-28-6473		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) 65 yrs Yrs.		8. Date of Birth (Month, Day, Year) Mar 7, 1931		9. Birthplace (State or Foreign Country) Maryland						
	10e. State Maryland														
To Be Completed by Funeral Director	10b. County Baltimore Co.		10c. City, Town or Location Reisterstown						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
	10e. Street and Number 23 Bon Bon Court				10f. Zip Code 21136		10g. Citizen of What Country? U.S.A								
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korea		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager (Service Stations)			16b. Kind of Business/Industry Annapolis Oil Co							
	17. Father's Name (First, Middle, Last) William H. Mixter				18. Mother's Name (First, Middle, Maiden Surname) Grace Schaffer										
	19a. Informant's Name/Relationship (Type, Print) Joan Mixter (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Bon Bon Court, Reisterstown, Maryland 21136										
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Cemetery		Date 8/3/96		20c. Location - City or Town, State Baltimore, Maryland								
	21. Signature of Funeral Service Licensee A. Alan Seitz, Jr.				22. Name and Address of Facility A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Baltimore, Maryland 21211										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Coronary Arteriosclerotic Cardiovascular Disease</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 3 years				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertension</u> <u>Diabetes</u>										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier Sheldon Goldgeier MD		29c. License number D02397		29d. Date signed (Month, Day, Year) 8/2/96	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sheldon Goldgeier 711 W 40 th Street Baltimore MD 21211															
31. Date filed (Month, Day, Year) AUG 05 1996 Julia Davidson-Randall															

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

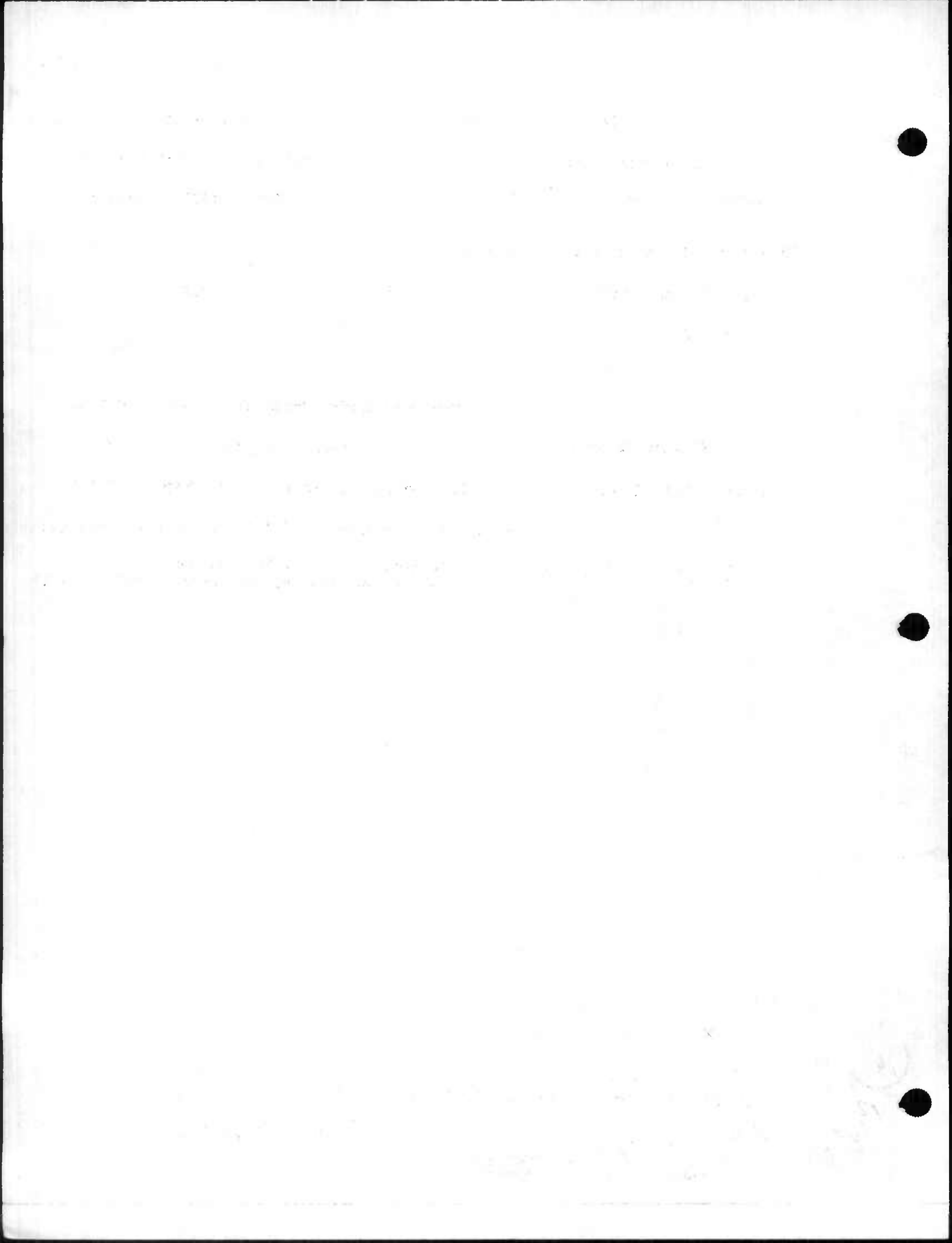
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23045

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HENRY A. MILLER

2. Date of Death

Month Day Year
AUGUST 2 1996

3. Time of Death

7:15 PM

4a. Facility Name (If not institution, give street and number)

6201 PEARCE AVENUE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

215-09-5622

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JUNE 1, 1916

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

6201 PEARCE AVENUE

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

STORE ATTENDANT

16b. Kind of Business/Industry

WESTINGHOUSE

17. Father's Name (First, Middle, Last)

JOSEPH MILLER

18. Mother's Name (First, Middle, Maiden Surname)

VERONICA SOMMER

19a. Informant's Name/Relationship (Type, Print)

JOAN RETTALIATA (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6201 PEARCE AVENUE - BALTIMORE, MD 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

NEW CATHEDRAL CEMETERY

Date

8/6/96

20c. Location - City or Town, State

BALTIMORE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HUBBARD FUNERAL HOME, INC.

4107 WILKENS AVENUE-BALTIMORE, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Prostate Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

1032543

29d. Date signed (Month, Day, Year)

8/3/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARK Stromberg, 7505 Osler DR. Towson MD

31. Date filed (Month, Day, Year)

AUG 05 1996

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23046

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LAURA NEWKIRK				2. Date of Death Month AUGUST Day 1 Year 1996		3. Time of Death 7:30 PM	
	4a. Facility Name (If not institution, give street and number) LIBERTY MEDICAL CENTER				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A	
Funeral Director	5. Social Security Number 245-10-9556		6. Sex 1 M 2 F XX		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) June 16 1906	
	9. Birthplace (State or Foreign Country) NORTH CAROLINA		10. Usual Residence of Decedent		10a. State MARYLAND		10b. County N/A	
To Be Completed by Funeral Director	10c. City, Town or Location BALTIMORE CITY		10d. Inside City Limits 1 Yes 2 No		10e. Street and Number 3111 BAKER STREET		10f. Zip Code 21216	
	10g. Citizen of What Country? U.S.A		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced XX		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No XX		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No XX Specify: BLACK	
	14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic		16b. Kind of Business/Industry PRIVATE HOME	
	17. Father's Name (First, Middle, Last) JERRY TWITTY		18. Mother's Name (First, Middle, Maiden Surname) ANNIE HUNT		19. Informant's Name/Relationship (Type, Print) SARAH BOLDEN/DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3111 Baker Street, Baltimore, Maryland 21216	
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARDEN OF ETERNAL HOPE		20c. Date 8-6-96		20d. Location - City or Town, State Carroll Co. Md.	
	21. Signature of Funeral Service Licensee William C. Brown		22. Name and Address of Facility William C. Brown Community F/H 1206 W. North Avenue		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BACTERIAL PNEUMONIA Due to (or as a consequence of): RENAL FAILURE Due to (or as a consequence of): URINARY TRACT INFECTIONS Due to (or as a consequence of):		Approximate interval Between Onset and Death 2 WEEKS	
	23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		24a. Was an autopsy performed? 1 Yes 2 No		24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
	25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)		27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Julia [Signature] MD		29c. License number D46529		29d. Date signed (Month, Day, Year) AUGUST 1 1996	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) VICTOR ONYEJAKA LIBERTY MEDICAL CENTER BALTIMORE MARYLAND		31. Date filed (Month, Day, Year) AUG 05 1996					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23047
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Baby Boy Nelson				2. Date of Death Month July Day 20 Year 1996		3. Time of Death 0447	
	4a. Facility Name (If not institution, give street and number) University of Maryland				4b. City, Town, or Location of Death Baltimore		4c. County of Death none	
Funeral Director	5. Social Security Number none		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months 3 Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 17, 1996	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Glen Burnie			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 1036 Fitzallen Road				10f. Zip Code 21060		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: unknown	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) none			16b. Kind of Business/Industry none	
17. Father's Name (First, Middle, Last) unknown				18. Mother's Name (First, Middle, Maiden Surname) Gretchen Nelson				
19a. Informant's Name/Relationship (Type, Print) Gretchen Nelson/Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1036 Fitzallen Road-Glen Burnie, Maryland 21060				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) State rem.				20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee Ronald S. Wade, Dir.				22. Name and Address of Facility State Anatomy board-655 W. Baltimore Street Baltimore, Maryland 21201-1559				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. Extreme Prematurity								
Due to (or as a consequence of):								
b. Premature Lungs								
Due to (or as a consequence of):								
c.								
Due to (or as a consequence of):								
d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and Title of Certifier Angela M. Patterson MD				
				29c. License number 046495		29d. Date signed (Month, Day, Year) July 20, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Angela M. Patterson MD 22 South Greene Street Balto MD 21209								
31. Date Used (Month, Day, Year) AUG 05 1996				32. Registrar's Signature Johanna Davidson-Randall				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23048

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Michael Norris</i>				2. Date of Death Month <i>Aug</i> Day <i>1</i> Year <i>96</i>		3. Time of Death <i>9:52 A.M.</i>	
	4a. Facility Name (If not institution, give street and number) <i>Union Memorial Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>NA</i>	
Funeral Director	5. Social Security Number <i>214-78-3605</i>		6. Sex <i>10 M 2 F</i>		7. Age (In yrs. last birthday) <i>37</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>MAR. 31, 1959</i>	
	9. Birthplace (State or Foreign Country) <i>MD</i>		10a. State <i>MD</i>		10b. County <i>NA</i>		10c. City, Town or Location <i>BALTIMORE</i>	
10d. Inside City Limits <i>1 X</i> Yes <i>2</i> No		10e. Street and Number <i>1034 BRADDISH AVE</i>		10f. Zip Code <i>21216</i>		10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <i>1 X</i> Never Married <i>2</i> Married <i>3</i> Widowed <i>4</i> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <i>1</i> Yes <i>2 X</i> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1</i> Yes <i>2 X</i> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) <i>NA</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Security Guard</i>		16b. Kind of Business/Industry <i>Low Office Building</i>				
17. Father's Name (First, Middle, Last) <i>Richard Norris</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>CELESTINE CARTER</i>				
19a. Informant's Name/Relationship (Type, Print) <i>CELESTINE NORRIS-MOTHER</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1034 Braddish Ave. Balto. Md. 21216</i>				
20a. Method of Disposition <i>1 X</i> Burial <i>2</i> Cremation <i>3</i> Removal from State <i>4</i> Donation <i>5</i> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>KING MEMORIAL PARK</i>		20c. Date <i>8-6-96</i>		20d. Location - City or Town, State <i>Randallstown Md</i>		
21. Signature of Funeral Service Licensee <i>Stephen B. Harris</i>		22. Name and Address of Facility <i>MAURICE F. H. WEST 4300 Wabash Avenue Balto, Md 21215</i>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <i>ACUTE RESPIRATORY FAILURE</i> Due to (or as a consequence of): b. <i>ASPIRATION PNEUMONIA</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death <i>24 HOURS</i>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>PITUITARY TUMOR S/P RESECTION</i>						23b. Did tobacco use contribute to the cause of death? <i>1</i> Yes <i>2</i> No <i>3</i> Probably <i>4 X</i> Unknown		
						24a. Was an autopsy performed? <i>1</i> Yes <i>2 X</i> No		
						24b. Were autopsy findings available prior to completion of cause of death? <i>1</i> Yes <i>2</i> No		
25. Was case referred to medical examiner? <i>1</i> Yes <i>2 X</i> No		26. Place of Death (Check only one) Hospital: <i>1</i> Inpatient <i>2</i> ER/Outpatient <i>3</i> DOA Other: <i>4 X</i> Nursing Home <i>5</i> Residence <i>6</i> Other (Specify)						
27. Manner of Death <i>1 X</i> Natural <i>5</i> Pending Investigation <i>2</i> Accident <i>6</i> Could not be determined <i>3</i> Suicide <i>4</i> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <i>1</i> Yes <i>2</i> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <i>1 X</i> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>2</i> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Alborah J. Pierce DO</i>		29c. License number <i>D45931</i>		29d. Date signed (Month, Day, Year) <i>August 1, 1996</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Deborah Irene Pierce 7220 Park Heights Ave 21208</i>								
31. Date filed (Month, Day, Year) <i>AUG 05 1996</i>		32. Registrar's Signature <i>John A. Wilson-Randall</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23049

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANK A NAKUOSAS				2. Date of Death Month 7 Day 31 Year 96		3. Time of Death 5:25 pm	
	4a. Facility Name (If not institution, give street and number) BALTIMORE VA HOSPITAL				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 215 18 6641		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 24, 1922	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 Yes 2 No	
10e. Street and Number 4814 Curtis Avenue				10f. Zip Code 21226		10g. Citizen of What Country? U.S.		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: W.W. II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Sunpaper		
17. Father's Name (First, Middle, Last) Anthony Nakuosas				18. Mother's Name (First, Middle, Maiden Surname) Salomia Pociute				
19a. Informant's Name/Relationship (Type, Print) Albina Kozlowski				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4814 Curtis Avenue Baltimore, Maryland 21226				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		Date 8/2/96		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee C. Richard Jones				22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic lung cancer Due to (or as a consequence of): b. peripheral vascular ischemia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 6 mos. 1 mo.
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accidental 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Jeannette Nazarian MD		29c. License number R8485		29d. Date signed (Month, Day, Year) 7/31/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeannette Nazarian, M.D., 10N. Greenest St. Balto.								
31. Date filed (Month, Day, Year) AUG 05 1996		32. Registrar's Signature Julia Wilson-Randall						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23050

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SHERMAN PETTEWAY				2. Date of Death Month Day Year JULY 30, 1996		3. Time of Death 3:30 am	
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death None	
Funeral Director	5. Social Security Number 063-58-8632		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 23 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 21, 1972	
	9. Birthplace (State or Foreign Country) New York City		10a. State Md		10b. County None		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 3730 Belle Ave		10f. Zip Code 21215		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12Th College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cert. Nursing Assistant		16b. Kind of Business/Industry Nursing Home			
	17. Father's Name (First, Middle, Last) Unknown		18. Mother's Name (First, Middle, Maiden Surname) Gracie Mae Stewart		19a. Informant's Name/Relationship (Type, Print) Pearline Stewart (Aunt)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1450 Taylor Ave. Bronx, New York 10460	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		20c. Location - City or Town, State Landsdowne, Md.		20d. Date 8/3/96	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility The Derrick C. Jones Funeral Home 4611 Park Heights Ave. Balto. Md. 21215		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute myelogenous leukemia Due to (or as a consequence of):		Approximate Interval Between Onset and Death 9 months	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier G. Scott Long MD PhD, Clinical Oncology Fellow		29c. License number D46331		29d. Date signed (Month, Day, Year) 7/30/96	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) G. Scott Long, 40 Johns Hopkins Oncology Center, 600 N Wolfe St, Baltimore MD 21207		31. Date filed (Month, Day, Year) AUG 05 1996		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23051

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sara Martha Phippin		2. Date of Death Month Day Year July 27 1996		3. Time of Death 1425
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO
Funeral Director	5. Social Security Number 217-28-4417	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	8. Date of Birth (Month, Day, Year) Aug. 28, 1924	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County Wicomico	10c. City, Town or Location Hebron		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 205 Connaway Street		10f. Zip Code 21830		10g. Citizen of What Country? U.S.A.
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Collega (1-4or 5+) 0		
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Own Home		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) John William Robert Adkins		18. Mother's Name (First, Middle, Maiden Surname) Bertha Lee Brown		
	19a. Informant's Name/Relationship (Type, Print) William Phippin/Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Connaway Street-Hebron, Maryland 21830		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State
	21. Signature of Funeral Service Licensee Ronald S. Wade, Dir.		22. Name and Address of Facility State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Myocardial Infarction Due to (or as a consequence of): b. Congestive Heart Failure Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 10 minutes		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Benjamin H. Meyer M.D.		29c. License number D30743		29d. Date signed (Month, Day, Year) 7/28/96	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benjamin H. Meyer M.D. 403 Quincy St. Salisbury, Md.					
31. Date filed (Month, Day, Year) AUG 05 1996		32. Registrar's Signature John Davidson-Randall			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23052

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jeannette H. Posluszny

2. Date of Death

August 2 1996

Day Year

3. Time of Death

11:58 AM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Ctr.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

217 20 0775

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 2, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

350 Folcroft Street

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housework

16b. Kind of Business/Industry

At Home

17. Father's Name (First, Middle, Last)

Adam Wysocki

18. Mother's Name (First, Middle, Maiden Surname)

Josephine Augustyniak

19a. Informant's Name/Relationship (Type, Print)

Leonard E. Posluszny, Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

350 Folcroft St. Balto., Md. 21224

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Green Mount Crematory

Data

8-5-96

20c. Location - City or Town, State

Balto., Md.

21. Signature of Funeral Service Licensee

Charles S. Zeiler

22. Name and Address of Facility

Charles S. Zeiler & Son Inc.
6224 Eastern Ave. Balto., Md.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Respiratory Failure; ARDS

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 wks

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Chronic myelogenous leukemia

Due to (or as a consequence of):

1 1/2 yrs.

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

congestive heart failure

coronary artery disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Kenneth Colley

29c. License number

96705

29d. Date signed (Month, Day, Year)

8/2/96

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Kenneth Colley, M.D. 4940 Eastern Ave. Balt. MD 21224

State
Registrar

31. Date filed (Month, Day, Year)

AUG 05 1996

32. Registrar's Signature

K. Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23053

Item 18, Film 738, 7/7/96, 1t

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carlton Hurt Poff				2. Date of Death Month July Day 31 Year 1996		3. Time of Death 2:15 AM	
	4a. Facility Name (If not institution, give street and number) 4526 Sykesville Road				4b. City, Town, or Location of Death Finksburg		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 212-38-0135		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) June 4, 1926	
	10a. State Md.		10b. County Carroll		10c. City, Town or Location Finksburg		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 4526 Sykesville Road				10f. Zip Code 21048		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) -				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeping Supervisor		16b. Kind of Business/Industry State Hospital	
	17. Father's Name (First, Middle, Last) Posey Poff				18. Mother's Name (First, Middle, Maiden Surname) Emma Puckett Pegie Era Puckett			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Catherine Wilda Poff				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4526 Sykesville Road Finksburg, Md. 21048			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crestlawn Mem. Gardens		Date 8/3/96		20c. Location - City or Town, State Marriottsville, MD.	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Harry W. Haight				22. Name and Address of Facility Haight Funeral Home P.O. Box 195 Sykesville, MD. 21784			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. GALL BLADDER CARCINOMA Due to (or as a consequence of): a. b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 3 mo			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how Injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Flavio Kruter			
	29c. License number D35398				29d. Date signed (Month, Day, Year) 7/31/96			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Flavio Kruter, MD - 684 A Poole Rd. Westminster, MD 21157							
	31. Date filed (Month, Day, Year) AUG 05 1996				32. Registrar's Signature John Davidson-Randall			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23054

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Raymond J. Rye

2. Date of Death

Month Day Year
August 3, 1996

3. Time of Death

8:30 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

2236 A Conowingo Rd.

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

5. Social Security Number

220 76 1118

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

37 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct 10, 1958

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2236 A Conowingo Rd.

10f. Zip Code

21015

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Fork Lift Operator

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Raymond H. Rye

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth E. Stachowiak

19a. Informant's Name/Relationship (Type, Print)

Julia A. Rye / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2236 A Conowingo Rd., Bel Air, MD 21015

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Green Mount Crematory 8/5/96

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CAFA Stephen D. Lohrmann P.A.
8717 Green Pastures Dr., Baltimore, MD 2128623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. Renal failure
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

10 yrs

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Insulin Dependant Diabetes
Due to (or as a consequence of):

20 yrs

c. Coronary artery Disease
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetic neuropathy

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was cause referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D 36715

29d. Date signed (Month, Day, Year)

August 3, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Scherif Osman, M.D., 39 Churchville Rd. #200, Bel Air, MD 21014

31. Date filed (Month, Day, Year)

AUG 05 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be dated for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

96 23055

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Thelma, Ryall</i>				2. DATE OF DEATH MONTH DAY YEAR <i>July 31 1996</i>		3. TIME OF DEATH <i>10:00 A M</i>	
4. SOCIAL SECURITY NUMBER <i>212-07-7490</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>77</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Nov. 24, 1918</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Lorien Nursing Home</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Columbia</i>		9c. COUNTY OF DEATH <i>Howard</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>MD</i>		10b. COUNTY <i>Howard</i>		10c. CITY, TOWN OR LOCATION <i>Ellicott City</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>9701 Hillsmere Road</i>				10f. ZIP CODE <i>21043</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>None</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Accountant</i>		15b. KIND OF BUSINESS/INDUSTRY <i>Telephone Company</i>			
17. FATHER'S NAME (First, Middle, Last) <i>John Aloysius Dorsey</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Emma Marie Kronenberg</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mildred Todd (Sister)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5046 Durham Road, Columbia, MD 21044</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Meadowridge Mem. Park Aug. 2, 1996</i>		20c. LOCATION — City or Town, State <i>Dorsey, MD</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert Gregory Brubaker</i>				22. NAME AND ADDRESS OF FACILITY <i>Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd. Columbia, MD 21045</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Stroke - Cerebrovascular disease</i>					Approximate Interval Between Onset and Death <i>acute</i>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <i>Cerebrovascular disease</i>					<i>chronic</i>
		c. <i>Atrial Fibrillation</i>					<i>chronic</i>
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>arteriosclerosis</i> <i>peripheral vascular disease</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard W. ...</i>				29c. LICENSE NUMBER <i>D31575</i>		29d. DATE SIGNED (Month, Day, Year) <i>July 31, 1996</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <i>KOLODRUBET Z 8501 Old Annapolis Rd Ellicott City MD 21042</i>							
31. DATE FILED (Month, Day, Year) <i>AUG 05 1996</i>				32. REGISTRAR'S SIGNATURE <i>John ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23056

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary A. Rodgers				2. Date of Death Month July Day 30th Year 1996				3. Time of Death 9:55 AM	
	4a. Facility Name (If not institution, give street and number) LIBERTY MEDICAL C ENE.				4b. City, Town, or Location of Death BALTIMORE CITY				4c. County of Death n/a	
Funeral Director	5. Social Security Number 219-26-4795		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 57 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth Month, Day, Year MAY 5, 1939		9. Birthplace (State or Foreign Country) N. CAROLINA		10a. State MD		10b. County na		10c. City, Town or Location BALTIMORE	
Usual Residence of Decedent		10d. Inside City Limits X Yes 2 No		10e. Street and Number 1543 MONTELIAR STREET		10f. Zip Code 21218		10g. Citizen of What Country? UNITED STATES		
11. Marital Status 1 Never Married 2 <input checked="" type="checkbox"/> Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4or 5+) -		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMECARE		16b. Kind of Business/Industry BALTIMORE CITY		17. Father's Name (First, Middle, Last) HEZEKIAH JONES		18. Mother's Name (First, Middle, Maiden Surname) BESSIE BELLAMY		19a. Informant's Name/Relationship (Type, Print) KAREN RODGERS		
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2301 EDEWING COURT, BALTIMORE, MD 21237		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PARK 8-3 RANDALLSTOWN, MARYLAND		20c. Location - City or Town, State		21. Signature of Funeral Service Licensee Vanessa Coats		
22. Name and Address of Facility WM. C. MARCFH.-1101 E. NORTH AVENUE		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Neuroleptic Malignant Syndrome Due to (or as a consequence of): Aspiration Pneumonia Due to (or as a consequence of): Encephalopathy Due to (or as a consequence of): Anemia		23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 <input checked="" type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sepsis renal failure Diabetes		25. Was case referred to medical examiner? 1 Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Terance L. Lamb M.D.		29c. License number D37203		29d. Date signed (Month, Day, Year) July 30th 1996		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Terance L. Lamb MD Liberty Medical Center, Baltimore, MD 21215		
31. Date filed (Month, Day, Year) AUG 05 1996		32. Registrar's Signature John Davidson-Randall								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23057

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Annie Mae Ray

2. Date of Death

July 30 1996 5:00 PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

JOSEPH RITCHIE HOSPICE

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

n/a

5. Social Security Number

213-36-7146

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

56

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUL 20, 1940

9. Birthplace (State or Foreign Country)

DARLINGTON, SC

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

4858 BOWLAND AVENUE

10f. Zip Code

21206

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ MarriedXX ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes XX ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 th

College (1-4or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SUPERVISOR DISTRIBUTION OPERATOR- U.S. POSTAL SERVICE

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

JOHN SIMON

18. Mother's Name (First, Middle, Maiden Surname)

FANNIE L. BRUNSON

19a. Informant's Name/Relationship (Type, Print)

SHARON MACLIN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2106 MEADOWVIEW AVENUE, BALTIMORE, MD 21207

20a. Method of Disposition

XX ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST VA CEM. 8-2 OWINGS MILLS, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Suzette K. Jones

22. Name and Address of Facility

WM. C. MARCHF H.-1101 E. NORTH AVENUE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Respiratory arrest

Due to (or as a consequence of):

b.

Renal cell carcinoma

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

minutes
8 hrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

XX ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John W. Payne, MD

29c. License number

D13012

29d. Date signed (Month, Day, Year)

31 July 96

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

6565 N. Charles St Baltimore, Md. - John Payne

31. Date filed (Month, Day, Year)

AUG 05 1996

32. Registrar's Signature

Lisa Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23058

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MYRTLE C. RAY				2. Date of Death Month 8 Day 3 Year 96		3. Time of Death 5:26 AM			
	4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A			
Funeral Director	5. Social Security Number 218-34-0851		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 4, 1915	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Baltimore			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 109 W. 11th Avenue				10f. Zip Code 21225		10g. Citizen of What Country? U.S.			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) 				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerical		16b. Kind of Business/Industry Cosmetician			
	17. Father's Name (First, Middle, Last) Parlett Townsley				18. Mother's Name (First, Middle, Maiden Surname) Dora Blakely					
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Norman Ray / Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 W. 11th Avenue Baltimore, Maryland 21225					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Data 8/5/96		20c. Location - City or Town, State Baltimore, Maryland			
	21. Signature of Funeral Service Licensee <i>Charles Gonce</i>				22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. CARDIOGENIC SHOCK Due to (or as a consequence of): b. RIGHT VENTRICULAR INFARCTION Due to (or as a consequence of): c. ACUTE INFREPOLATERAL MYOCARDIAL INFARCTION Due to (or as a consequence of): d. SEVERE CORONARY ARTERY DISEASE								Approximate Interval Between Onset and Death 2 hours 2 1/2 hours 2 1/2 hours 7 years	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Diabetes, Hypochlosterolemia								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier David B. Aick (MD)		29c. License number D42668		29d. Date signed (Month, Day, Year) 8/3/96			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Aick 203 Hospital Dr. Suite 206 Glen Burnie MD 21061									
State Registrar	31. Date filed (Month, Day, Year) AUG 05 1996		32. Registrar's Signature <i>Don Randall</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

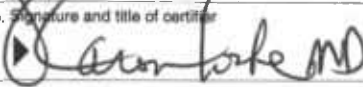

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) BARRY		2. Date of Death Month JULY Day 31 Year 1996		3. Time of Death 10:22 PM	
4a. Facility Name (If not institution, give street and number) ST. AGNES HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
5. Social Security Number 083-40-8152		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 35 Yrs.	
8. Date of Birth (Month, Day, Year) AUG 3, 1960		9. Birthplace (State or Foreign Country) NY			
Usual Residence of Decedent					
10a. State FL		10b. County Martin		10c. City, Town or Location Palm City	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2663 S.W. Greenwich Way		10f. Zip Code 34990	
10g. Citizen of What Country? USA		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Senior Director		16b. Kind of Business/Industry Information Systems		17. Father's Name (First, Middle, Last) Walter Rappaport	
18. Mother's Name (First, Middle, Maiden Surname) Jean Sapol		19a. Informant's Name/Relationship (Type, Print) Walter Rappaport/Father		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2663 S.W. Greenwich Way, Palm City, FL 34990	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) New Montefiore		20c. Date 8/4/96	
20d. Location, City or Town, State PINELAWN, NY Brooklyn, NY		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc. 5695 Main Street, Elkrigde, MD 21227	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. CORONARY ARTERY STENOSIS Due to (or as a consequence of): b. CORONARY ARTERY VASCULITIS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) AUG. 01, 1996	
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) J. LARSON, MD 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) AUG 05 1996		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23060

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN T. RYDZEWSKI

2. Date of Death

Month 7 Day 27 Year 96

3. Time of Death

11:03p

4a. Facility Name (If not institution, give street and number)

HORIZON SPECIALTY CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

217-07-8244

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
11-23-12

9. Birthplace (State or Foreign Country)

N/A

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

323 MADERIA STREET

10f. Zip Code

21231

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8 YEARS

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LONG SHORMAN

16b. Kind of Business/Industry

ILA

17. Father's Name (First, Middle, Last)

WALTER RYDZEWSKI

18. Mother's Name (First, Middle, Maiden Surname)

LOUISE BARNAS

19a. Informant's Name/Relationship (Type, Print)

MR. ANDREW RYDZEWSKI

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8304 cove road BALTO. MD. 21222

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. STANISLAUS CEM.

Date

7-31-96 BALTO. MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Charles R. Kaczorowski

22. Name and Address of Facility

KACZOROWSKI FUNERAL HOME
1201 DUNDALK AVE. BALTO. MD. 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPTICEMIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cerebral Vascular Accident

Due to (or as a consequence of):

6 yrs.

c. (R) hemiparesis

Due to (or as a consequence of):

6 yrs

d. HTN

10 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aphasia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No25. Was case referred to medical examiner?
☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

7/29/96

28b. Time of Injury

4:03 PM

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

N/A

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

N/A

28t. Location (Street and Number or Rural Route Number, City or Town, State)

N/A

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J G Shearer

29c. License number

S47879

29d. Date signed (Month, Day, Year)

7/29/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHEARER, JULIE

2801 Hudson St
Balt MD 21224State
Registrar

31. Date filed (Month, Day, Year)

AUG 05 1996

32. Registrar's Signature

Julie Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

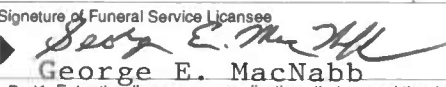

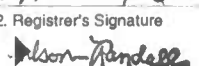
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23061

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Eleanor Reiter				2. Date of Death Month AUG Day 02 Year 1996				3. Time of Death 6:30 AM					
	4a. Facility Name (If not institution, give street and number) 2537 Old Kays Mill Road				4b. City, Town, or Location of Death Finksburg				4c. County of Death Carroll					
Funeral Director	5. Social Security Number 212-60-2023		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 45 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) April 9, 1951		9. Birthplace (State or Foreign Country) New York	
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State Maryland		10b. County Carroll		10c. City, Town or Location Finksburg				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	10e. Street and Number 2537 Old Kays Mill Road				10f. Zip Code 21048				10g. Citizen of What Country? USA					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse				16b. Kind of Business/Industry Hospital					
	17. Father's Name (First, Middle, Last) Robert Walter Madden				18. Mother's Name (First, Middle, Maiden Surname) Eleanor Grace Curtin									
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) James Thomas Reiter, Jr./Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2537 Old Kays Mill Rd. Finksburg, MD 21048									
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.				Date 8/3/96		20c. Location - City or Town, State Baltimore, MD			
	21. Signature of Funeral Service Licensee  George E. MacNabb				22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228									
	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. Recurrent ovarian carcinoma Due to (or as a consequence of): b. Cardiorespiratory Arrest Due to (or as a consequence of): c. Due to (or as a consequence of): d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown													
State Registrar	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number D-20637		29d. Date signed (Month, Day, Year) Aug 2, 1996			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Francis C. Crumrine, 6569 N. Charles St., Towson, Md. 21204													
31. Date filed (Month, Day, Year) AUG 05 1996				32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23062

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary L. Shapiro

2. Date of Death

August 3, 1996

3. Time of Death

0619

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview M.C.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

220-22-8279

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JAN. 3 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

Anglesea Street 1108

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

4

College (1-4or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

FRANK

Zellers

18. Mother's Name (First, Middle, Maiden Surname)

ANNA Devlin

19a. Informant's Name/Relationship (Type, Print)

Jack Shapiro (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Anglesea St. 1108 Balt, MD 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn

Date

August 6

20c. Location - City or Town, State

East Point, Maryland

21. Signature of Funeral Service Licensee

Mark A. Chomicki

22. Name and Address of Facility

W. Dabrowski / Chojnacki, F.H.P.A.
1005 Dundalk Ave. BALTO, MD 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Respiratory arrest

Approximate Interval Between Onset and Death

30 min.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Congestive heart failure

8 hrs. / 3 yrs.

Due to (or as a consequence of):

myocardial infarction

8 hrs. / 3 yrs.

Due to (or as a consequence of):

coronary artery disease

10 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

coronary artery disease

peripheral vascular disease

chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mark A. Chomicki

29c. License number

96705

29d. Date signed (Month, Day, Year)

8/3/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kenneth Colley MD 4940 Easton Ave. Balt. MD 21224

31. Date filed (Month, Day, Year)

AUG 05 1996

32. Registrar's Signature

John Burdon-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed and signed within 48 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23063

ITEM#1 film g738 8/5/96ag perFH

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KIRBY SPEARMAN CURBIE SPEARMAN				2. Date of Death Month Day Year JULY 30, 1996		3. Time of Death 8:19am	
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death n/a	
Funeral Director	5. Social Security Number 216-10-7387		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		6. Date of Birth Month Day Year OCT. 5, 1912	
	9. Birthplace (State or Foreign Country) N. CAROLINA		Usual Residence of Decedent		10a. State MD		10b. County n/a	
To Be Completed by Funeral Director	10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1012 E. BIDDLE STREET		10f. Zip Code 21202	
	10g. Citizen of What Country? UNITED STATES		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 12/43-2/46		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
To Be Completed by Physician/Medical Examiner	14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OPERATING ENGINEER		16b. Kind of Business/Industry CONSTRUCTION	
	17. Father's Name (First, Middle, Last) JOHN SPEARMAN		18. Mother's Name (First, Middle, Maiden Surname) HATTIE JOHNSON		19a. Informant's Name/Relationship (Type, Print) SADIE SPEARMAN		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1012 E. BIDDLE STREET, BALTIMORE, MD #02	
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST VA CEM.		20c. Location - City or Town, State OWINGS MILLS, MD		20d. Date 8-5	
	21. Signature of Funeral Service Licensee <i>Vanessa</i>		22. Name and Address of Facility WM. C. MARCFH.-1101 E. N ORTH AVENUE		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last e. Uremia Due to (or as a consequence of): f. Hepato cellular Carcinoma Due to (or as a consequence of): g. Due to (or as a consequence of): h.		Approximate Interval Between Onset and Death 2 days 6 months	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Cardio myopathy				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To the Hospital or attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospice: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
State Registrar	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Ethan J. Weiss, M.D. Medicine Resident</i>		29c. License number MS717		29d. Date signed (Month, Day, Year) 7/30/96	
DHM 16 Rev 6/95	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ETHAN J. WEISS, M.D. TOWER 110 Johns Hopkins Hospital, Baltimore, MD 21205				31. Date filed (Month, Day, Year) AUG 05 1996			
	32. Registrar's Signature <i>John Davidson-Randall</i>							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23064

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Marie Sullivan</i>				2. Date of Death Month <i>July</i> Day <i>31</i> Year <i>1996</i>		3. Time of Death <i>9:29 PM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Union Memorial Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore City</i>		4c. County of Death <i>N/A</i>	
Funeral Director	5. Social Security Number <i>257-15-9896</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>84</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Oct. 1, 1911</i>	9. Birthplace (State or Foreign Country) <i>France</i>
	Usual Residence of Decedent							
10a. State <i>Md.</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>4207 Linkwood Road</i>				10f. Zip Code <i>21210</i>		10g. Citizen of What Country? <i>U.S.A.</i>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>		16b. Kind of Business/Industry <i>Own Home</i>		
17. Father's Name (First, Middle, Last) <i>Pierre Pelissier</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Nancy Adams</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Christy M. Krug (Daughter)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4207 Linkwood Road Baltimore, Maryland 21210</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other) <i>Baltimore National Cemetery</i>		Date <i>August 5, 1996</i>		20c. Location - City or Town, State <i>Baltimore, Maryland</i>	
21. Signature of Funeral Service Licensee <i>Michael</i>				22. Name and Address of Facility <i>Witzke Funeral Home, Inc. 1630 Edmondson Avenue Catonsville, Maryland</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)								
a. <i>Exsanguinated from Right Atrial Rupture</i>								<i>30 min</i>
Due to (or as a consequence of):								
b. <i>Coronary Artery Disease Bypass Operation</i>								<i>3 hours</i>
Due to (or as a consequence of):								
c. <i>Coronary Artery Disease</i>								<i>2 days</i>
Due to (or as a consequence of):								
d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and Title of certifier <i>Eric Daniel Wellons MD</i>		29c. License number <i>AT-2438946-823</i>		29d. Date signed (Month, Day, Year) <i>July 31, 1996</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>ERIC DANIEL WELLONS Union Memorial Hospital</i>								
31. Date filed (Month, Day, Year) <i>AUG 05 1996</i>				32. Registrar's Signature <i>Julia Davidson</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH REG. NO.

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Beatrice Stedtler				2. DATE OF DEATH MONTH Aug DAY 2 YEAR 1998 5:55 PM	
4. SOCIAL SECURITY NUMBER 217-12-3937		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 87 YRS.	7. DATE OF BIRTH (Month, Day, Year) March 19, 1909	
8a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital				8b. CITY, TOWN OR LOCATION OF DEATH Baltimore City	
9. RESIDENCE OF DECEDENT				9c. COUNTY OF DEATH N/A	
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER 3201 Frisby Street				10f. ZIP CODE 21218	
10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Assistant Buyer		16b. KIND OF BUSINESS/INDUSTRY Retail	
17. FATHER'S NAME (First, Middle, Last) Louis Stedtler				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sophia Boucher	
19a. INFORMANT'S NAME (Type/Print) Mark Brown Attorney		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 Carriage Walk Court Baltimore, Maryland 21234			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt Carmel Cemetery 8/6		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dennis Hyslop Knack		22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212			
23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebrovascular accident Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. Hypertension c. DUE TO (OR AS A CONSEQUENCE OF): d.					
24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days 710 yrs					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER Nkiri m				29c. LICENSE NUMBER AT 2438.946	
29d. DATE SIGNED (Month, Day, Year) Aug 02 1998					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NANDINI KIRI M.D. 201 E. UNIV. PARKWAY, BALTIMORE, MD 21218					
31. DATE FILED (Month, Day, Year) AUG 05 1998		32. REGISTRAR'S SIGNATURE John Davidson			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23066

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas William Simpson

2. Date of Death

Month Day Year
July 30, 1996

3. Time of Death

7:30 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

213-60-8934

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
Dec. 13, 1947

9. Birthplace (State or Foreign Country)

Mississippi

Usual Residence of Decedent

10a. State

Delaware

10b. County

New Castle

10c. City, Town or Location

Bear

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

819 Seymour Road

10f. Zip Code

19701

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
10 Years

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Contractor

16b. Kind of Business/Industry

Contracting

17. Father's Name (First, Middle, Last)

Hine Simpson

18. Mother's Name (First, Middle, Maiden Summa)

Evelyn Evans

19a. Informant's Name/Relationship (Type, Print)

Mrs. Epplina Simpson/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

819 Seymour Road New Castle, Delaware 19701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Lawn Croft Cemetery 8/6/1996

Data

20c. Location - City or Town, State

Linwood, Pennsylvania

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Brain Tumor

Approximate
Interval Between
Onset and Death

27 Days

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation
6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

29c. License number

M5227

29d. Date signed (Month, Day, Year)

July 30th, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raymond I H. Jr. 420 N. Wolfe St. Baltimore MD

31. Date filed (Month, Day, Year)

AUG 05 1996

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo be Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23067

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HABAKKUK LENORA SPEAKS

2. Date of Death

Month Day Year
August 1, 1996

3. Time of Death

1:10 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

5025 Westhills Road (res.)

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

219-26-7659

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

58

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 14, 1938

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5025 Westhills Road

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Order Picker/Filler

16b. Kind of Business/Industry

UNKNOWN

17. Father's Name (First, Middle, Last)

John Speaks

18. Mother's Name (First, Middle, Maiden Surname)

Beatrice Crafton

19a. Informant's Name/Relationship (Type, Print)

Gloristine Vines

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5025 Westhills Rd, Baltimore, MD 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Memorial Park 8/5

Date

20c. Location - City or Town, State

Arbutus, Maryland

21. Signature of Funeral Service Licensee

Leroy O. Dyett

22. Name and Address of Facility

LEROY O. DYETT & SON FUNERAL HOME, P.A.
4600 LIBERTY HEIGHTS AVENUE, BALTO. 21207

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic lung cancer to brain

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Matilda H. So, MD

29c. License number

D 26250

29d. Date signed (Month, Day, Year)

8/2/1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATILDA H. So, 1447 York Rd, Lutherville, MD 21093

31. Date filed (Month, Day, Year)

AUG 05 1996

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed within 72 hours after death.

To the Hospital or Attending Physician: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

ITEM#1 film g738 8/5/96ag perFH

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DENNIS ROSHAWN SAMPSON				2. Date of Death Month Day Year JULY 27, 1996		3. Time of Death 3:46 PM	
	4a. Facility Name (If not institution, give street and number) 1233 E. BELVEDERE AVE.				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 218-58-2340		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 32 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) APR 14, 1964	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent 10a. State Maryland 10b. County N/A 10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 1233 E. BELVEDERE AVE		10f. Zip Code 21239		10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) 12th grade		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Private Business				
17. Father's Name (First, Middle, Last) JAMES EDWARD SAMPSON				18. Mother's Name (First, Middle, Maiden Surname) IRENE PATRICIA ANN DERRY				
19a. Informant's Name/Relationship (Type, Print) PATRICIA A. WATTS				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1233 E. BELVEDERE AVE BALTIMORE, MD 21235				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) EMMANUEL U.M. CHURCH		Date 8-2-96		20c. Location - City or Town, State CHESTERTOWN, MD		
21. Signature of Funeral Service Licensee Quay Harris		22. Name and Address of Facility CHAPMAN - ADAMS L.I. 5240 REISTERSTOWN ROAD BALTIMORE, MD 21215						
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. NARCOTIC INTOXICATION								Approximate Interval Between Onset and Death
e. Due to (or as a consequence of):								
b. Due to (or as a consequence of):								
c. Due to (or as a consequence of):								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 7-27-96 FOUND		28b. Time of Injury 3:35 P M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred SUBJECT INGESTED DRUGS
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated.		29b. Signature and title of certifier Dennis J. Chute		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 28, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) AUG 05 1996		32. Registrar's Signature Johanna Davidson-Randall						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

[Faint signature or text at the bottom center of the page.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23069

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JANINE SCHELL				2. Date of Death Month Day Year JULY 31, 1996		3. Time of Death 7:30PM	
	4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 212-28-5047		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	8. Date of Birth (Month, Day, Year) Nov. 11, 1924	9. Birthplace (State or Foreign Country) France		
	Usual Residence of Decedent				10. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Timonium		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 26 Salthill Road		10f. Zip Code 21093		10g. Citizen of What Country? U.S.A.			
	11. Marital Status unknown <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Payroll Clerk		16b. Kind of Business/Industry unknown			
	17. Father's Name (First, Middle, Last) Jean George Huck				18. Mother's Name (First, Middle, Maiden Surname) Marcelle Renne Cuny			
	19a. Informant's Name/Relationship (Type, Print) Milton J. Brownstein/Friend				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26 Salthill Road-Timonium, Maryland 21093			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee Ronald S. Wade, Dir.				22. Name and Address of Facility State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Non Hodgkins' Lymphoma Due to (or as a consequence of):							Approximate interval Between Onset and Death 10 mos
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Paul Celano, M.D.				29c. License number D30929		29d. Date signed (Month, Day, Year) 7/31/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Celano, MD 6569 N. Charles St, BALTIMORE, MD 21204								
31. Date filed (Month, Day, Year) AUG 05 1996				32. Registrar's Signature Julia Burdon-Randall				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report is a general introduction to the subject of the study.

2. The second part of the report is a detailed description of the methods used in the study.

3. The third part of the report is a presentation of the results of the study.

4. The fourth part of the report is a discussion of the results and their implications.

5. The fifth part of the report is a conclusion and a list of references.

6. The sixth part of the report is a list of appendices.

7. The seventh part of the report is a list of figures and tables.

8. The eighth part of the report is a list of footnotes.

9. The ninth part of the report is a list of acknowledgments.

10. The tenth part of the report is a list of abbreviations.

11. The eleventh part of the report is a list of symbols.

12. The twelfth part of the report is a list of references.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23070

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sophie E. Smith				2. Date of Death Month Day Year AUG 3, 1996		3. Time of Death 3:40 AM		
	4a. Facility Name (If not Institution, give street and number) Manor Care Nursing & Rehabilitation Center / Towson				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 405-07-9385		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 30, 1900		9. Birthplace (State or Foreign Country) Indiana
	Usual Residence of Decedent 10a. State Maryland 10b. County Baltimore 10c. City, Town or Location Towson 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 509 E. Joppa Road		10f. Zip Code 21286		10g. Citizen of What Country? USA
To Be Completed by Funeral Director	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Telephone Operator				16b. Kind of Business/Industry AT&T		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Henry Wilbers				18. Mother's Name (First, Middle, Maiden Surname) Barbara Wagner				
	19a. Informant's Name/Relationship (Type, Print) Anne Kathryn Oppel/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7200 Third Ave., C104 Sykesville, MD 21784				
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. 08/03/96		20c. Location - City or Town, State Baltimore, MD		21. Signature of Funeral Service Licensee George E. MacNabb		
	22. Name and Address of Facility Cremation Society of Md., Inc. 299 Frederick Road Balto., MD 21228		23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Vrosepsis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate interval between Onset and Death 4 hours						
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	23b. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Dementia				23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
State Registrar	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
State Registrar	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Richard J. [Signature]		29c. License number D18758		29d. Date signed (Month, Day, Year) August 3, 1996		
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Suite 300, 20 E. [Address], [City] Md. 21093								
	31. Date filed (Month, Day, Year) AUG 05 1996		32. Registrar's Signature [Signature]						

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Gaither Thornton Jr.				2. DATE OF DEATH MONTH July DAY 30 YEAR 1996		3. TIME OF DEATH 09:35 p.m.	
4. SOCIAL SECURITY NUMBER 216 501144		5. SEX 1 M 2 F	6. AGE (In yrs. last birthday) 46 YRS.	7. DATE OF BIRTH (Month, Day, Year) OCT. 27, 1949		8. BIRTHPLACE (State or Foreign Country) BALTIMORE, MD	
9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH n/a	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 YES 2 NO	
10e. STREET AND NUMBER 211 N. MADERIA STREET				10f. ZIP CODE 21231		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 XX Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 10th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER		16b. KIND OF BUSINESS/INDUSTRY SANITATION DEPT.			
17. FATHER'S NAME (First, Middle, Last) GAITHER B. THORNTON SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) AGNES SWANN			
19a. INFORMANT'S NAME (Type/Print) AGNES THORNTON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 N. MADERIA ST., BALTIMORE, MD 21231			
20a. METHOD OF DISPOSITION 1 XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) CEDAR HILL CEMETERY 8-5		20c. LOCATION — City or Town, State ANNE ARUNDEL CO, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Vanessa Cook				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH. 1101 E. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS							19 days
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. NECROTIC VEGETATIVE ENDOCARDITIS							3 months
DUE TO (OR AS A CONSEQUENCE OF):							
c. INTRAVENOUS DRUG ABUSE							20 years
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 Pending Investigation 2 Accident 3 Suicide 4 Homicide 8 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Kathleen M. Walcott, M.D.				29c. LICENSE NUMBER AT2438946		29d. DATE SIGNED (Month, Day, Year) July 30, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kathleen M. Walcott, 5010 Lincoln Ave., Beltsville, MD 20705							
31. DATE FILED (Month, Day, Year) AUG 05 1996		32. REGISTRAR'S SIGNATURE Julia Davidson-Rendell					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 681, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) Isabelle D. Thomas				2. DATE OF DEATH MONTH 07 DAY 28 YEAR 96				3. TIME OF DEATH 555 a.m.							
4. SOCIAL SECURITY NUMBER 265-18-6486		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 95 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____		7. DATE OF BIRTH (Month, Day, Year) 12-03-01		8. BIRTHPLACE (State or Foreign Country) Georgia			
9a. FACILITY NAME (If not institution, give street and number) Dulaney Towson Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Towson				9c. COUNTY OF DEATH Baltimore							
RESIDENCE OF DECEDENT				10a. STATE Maryland				10b. COUNTY Baltimore				10c. CITY, TOWN OR LOCATION Towson			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 111 West Road				10f. ZIP CODE 21204				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Newspaper Proof Reader		16b. KIND OF BUSINESS/INDUSTRY New Media											
17. FATHER'S NAME (First, Middle, Last) Ernest Dunn				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Elizabeth Brown											
19a. INFORMANT'S NAME (Type/Print) Bessie Claire Neal/Daughter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11095-H Tarragon Road-Reisterstown, MD. 21136-3153											
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald S. Wade, Dir.				22. NAME AND ADDRESS OF FACILITY State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. SICK SINUS SYNDROME DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____								Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. FEBRILE ILLNESS								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M _____		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)													
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER Robert H. Wiedefeld MD				29c. LICENSE NUMBER D33011		29d. DATE SIGNED (Month, Day, Year) 7/28/96									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT H. WIEDEFELD MD 3346 PAPERMILL Rd Pikesville Md 21131															
31. DATE FILED (Month, Day, Year) AUG 05 1996				32. REGISTRAR'S SIGNATURE Davidson-Randall											

19-22-61

21

21

21

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23073

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DAVID TRAYLOR

2. Date of Death

Month Day Year
August 1st 1996

3. Time of Death

12:10 AM

4a. Facility Name (If not institution, give street and number)

CHURCH HOME HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-01-8458

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
JUNE 16, 1906

9. Birthplace (State or Foreign Country)

SC.

Usual Residence of Decedent

10e. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

605 BENNINGHAUS ROAD

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12th

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

FOREMAN

16b. Kind of Business/Industry

CHEMICAL

17. Father's Name (First, Middle, Last)

JOHN TRAYLOR

18. Mother's Name (First, Middle, Maiden Surname)

LYDIA TRAYLOR

19a. Informant's Name/Relationship (Type, Print)

HOWARD SHAVERS (STEPSON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

605 BENNINGHAUS ROAD BALTO, MD. 21212

20e. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

BALTIMORE CEMETERY 8/5/96

Data

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CAPLE FUNERAL SERVICE
5502 WINNER AVENUE BALTIMORE, MD 21215

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

e. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 WEEK.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OBSTRUCTIVE AIRWAY DISEASE.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide28e. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

D 46893

29d. Date signed (Month, Day, Year)

August 1st 1996.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. SARKOBE - ADD, CHURCH HOSPITAL 301 N BROADWAY HOSP.

31. Date filed (Month, Day, Year)

AUG 05 1996

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ESTA BEULAH TAWNEY			2. Date of Death Month Day Year AUG. 03, 1996		3. Time of Death 3:33 PM		
	4a. Facility Name (If not institution, give street and number) CARROLL COUNTY HOSPITAL			4b. City, Town, or Location of Death WESTMINSTER		4c. County of Death Carroll		
Funeral Director	5. Social Security Number 234-30-8655		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 24, 1921	
	9. Birthplace (State or Foreign Country) West Virginia		10a. State Maryland		10b. County Carroll		10c. City, Town or Location Finksburg	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 3329 Old Westminster Pike		10f. Zip Code 21048		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Homemaker		17. Father's Name (First, Middle, Last) Robert Coombs	
	18. Mother's Name (First, Middle, Maiden Surname) Rose Davis		19a. Informant's Name/Relationship (Type, Print) Leonard H. Tawney- Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3329 Old Westminster Pike, Finksburg, Md. 21048		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Mem. Gardens Aug. 6, 1996		20c. Location - City or Town, State Finksburg, Md.		21. Signature of Funeral Service Licensee J. Eckhardt		22. Name and Address of Facility Eckhardt Funeral Chapel 11605 Reisterstown Rd. Owings Mills, Md. 21117	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Donald G. Wright MD		29c. License number O.C.M.E.	
State Registrar	29d. Date signed (Month, Day, Year) AUG. 04, 1996		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Donald G. Wright M.D. 111 Penn Street, Baltimore, Maryland 21201		31. Date filed (Month, Day, Year) AUG 05 1996		32. Registrar's Signature Julia K. [Signature]	

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23075

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name John R. WALKER Sr.				2. Date of Death Month AUGUST Day 01 Year 1996		3. Time of Death 10:15 PM	
	4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL CENTER				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE CITY	
Funeral Director	5. Social Security Number 415 26 1617		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 15, 1924	
	9. Birthplace (State or Foreign Country) Tennessee		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10e. Street and Number 2903 Delaware Avenue		10f. Zip Code 21227		10g. Citizen of What Country? U.S.		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) Collage (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) General Contractor		16b. Kind of Business/Industry Construction			
	17. Father's Name (First, Middle, Last) Robert E. Walker				18. Mother's Name (First, Middle, Maiden Surname) Isabelle Disney			
	19a. Informant's Name/Relationship (Type, Print) Sharon L. Walker / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2903 Delaware Avenue Baltimore, Maryland 21227			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lorraine Park		20c. Location - City or Town, State 8/5/96 Woodlawn, Maryland			
	21. Signature of Funeral Service Licensee <i>Richard E. Davis</i>				22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. PNEUMONIA Due to (or as a consequence of): b. TRACHEO-ESOPHAGIAL FISTULA Due to (or as a consequence of): c. ESOPHAGIAL CANCER Due to (or as a consequence of): d.							
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. LUNG CANCER								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined								
28a. Date of Injury (Month, Day Year) 8/5/96								
28b. Time of Injury M								
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
28d. Describe how injury occurred								
28e. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Gabriel H.D.</i>								
29c. License number AS2441616								
29d. Date signed (Month, Day, Year) AUGUST 01 1996								
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SOLMON G. GHIDE HARBOR HOSPITAL CENTER 3001 S. HANOVER ST BALTIMORE MD 21225								
31. Date filed (Month, Day, Year) AUG 05 1996								
32. Registrar's Signature <i>J. ...</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

hospital or attending physician: The law requires that the death certificate be executed within 4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23076

ITEM#20b film g738 8/5/96ag perFH

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Wise WHITE				2. Date of Death Month Day Year August 1st 1996		3. Time of Death 3:00 pm	
	4a. Facility Name (If not institution, give street and number) Bon Secours Hospital				4b. City, Town, or Location of Death Balto		4c. County of Death NIA	
Funeral Director	5. Social Security Number 212-14-2066 A		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) Feb 1, 1910	
	9. Birthplace (State or Foreign Country) md		10a. State md		10b. County NIA		10c. City, Town, or Location Balto	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 107 n. Hilton St.		10f. Zip Code 21229		10g. Citizen of What Country? U.S.A	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Coin Counter		16b. Kind of Business/Industry Federal Reserve Bank			
	17. Father's Name (First, Middle, Last) William White				18. Mother's Name (First, Middle, Maiden Surname) Sophomria Wise			
	19a. Informant's Name/Relationship (Type, Print) Elizabeth White - wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 n. Hilton St. Balto, md 21229			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) 107 n. Hilton St. Balto, md		20c. Location - City or Town, State Balto, md			
	21. Signature of Funeral Service Licensee Glynis B. Hanes				22. Name and Address of Facility March F. H. West 4300 Wabash Ave			
	23a. Part 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia STROKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 3 WEEKS 3 WEEKS							
	23b. Part 2: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. RENAL FAILURE							
	Physician /Medical Examiner	23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accidental 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicidal		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier S. J. Hanes, MD		29c. License number D48006		29d. Date signed (Month, Day, Year) August 1st 1996				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kofi Owusu-Boateng, 2000 W. BALTIMORE ST, BALTIMORE 21223								
31. Date filed (Month, Day, Year) AUG 05 1996		32. Registrar's Signature Julia Davidson-Randall						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital for Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 23077**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EUGENE WENCZKOWSKI				2. Date of Death Month JULY Day 26 Year 1996		3. Time of Death 21:48	
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death none	
Funeral Director	5. Social Security Number unknown	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 9, 1940		9. Birthplace (State or Foreign Country) unknown
	Usual Residence of Decedent							
10a. State Maryland		10b. County none		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10a. Street and Number 112 Haven Street				10f. Zip Code 21224		10g. Citizen of What Country? U.S.A.		
11. Marital Status unknown <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown		16b. Kind of Business/Industry unknown		
17. Father's Name (First, Middle, Last) unknown				18. Mother's Name (First, Middle, Maiden Summa) unknown				
19a. Informant's Name/Relationship (Type, Print) unknown				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) State rem.		20b. Place of Disposition (Name of cemetery, crematory or other place) in		Data		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee Ronald S. Wade, Dir.				22. Name and Address of Facility State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Pneumonia Due to (or as a consequence of): c. Alcoholism Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last {								Approximate Interval Between Onset and Death 24 hours 2 days
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. hepatomegaly Circulatory Collapse Metabolic acidosis						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature]		29c. License number 169404		29d. Date signed (Month, Day, Year) 7/26/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David G. Friedenson, MD Johns Hopkins Hospital 603 N. Wolfe St Baltimore, MD								
31. Date filed (Month, Day, Year) AUG 05 1996		32. Registrar's Signature [Signature]						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

96-4350-510

ITEMS: 23 PART I, 27, 28a-f, PER
ME0 F1LM G-738 8/15/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

96 23078

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HOWARD CORNELIUS WHYE		2. Date of Death Month AUGUST Day 2 Year 1996		3. Time of Death 9:40 P.M.
	4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
Funeral Director	5. Social Security Number 215-68-3145	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 39 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) OCT 29, 1956		9. Birthplace (State or Foreign Country) MARYLAND		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State MD.		10b. County N/A
	10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 4714 ALHAMBRA STREET		10f. Zip Code 21212		10g. Citizen of What Country? USA
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 4-19-77		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: BLACK
	14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER
	16b. Kind of Business/Industry CONCRETE		17. Father's Name (First, Middle, Last) HOWARD C. WHYE		18. Mother's Name (First, Middle, Maiden Surname) EVELYN J. FRAZIER
	19a. Informant's Name/Relationship (Type, Print) EVELYN J. WHYE (MOTHER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4714 ALHAMBRA ST. BALTIMORE, MD 21212		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) PLEASANT REST CEM 8/7/96		20c. Location - City or Town, State TOWSON, MD.
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility CAPLE FUNERAL SERVICE 5502 WINNER AVENUE BALTIMORE, MD. 21215		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ALCOHOL, COCAINE AND NARCOTIC INTOXICATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Approximate Interval Between Onset and Death		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) UNKNOWN		28b. Time of Injury UNKNOWN M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred UNKNOWN		28e. Location (Street and Number or Rural Route Number, City or Town, State) UNKNOWN	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E.	
29d. Date signed (Month, Day, Year) AUGUST 3, 1996		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201			
31. Date filed (Month, Day, Year) AUG 05 1996		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23079

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

LUTHER DEAN ZWEIER

2. Date of Death

Month Day Year
July 30, 1996

3. Time of Death

9:00PM

4a. Facility Name (If not institution, give street and number)

812 Stoneleigh Road

4b. City, Town, or Location of Death

Stoneleigh

4c. County of Death

Baltimore County

5. Social Security Number

159-18-6301

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Oct. 26, 1915 Pennsylvania

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland Baltimore County

10b. County

10c. City, Town or Location

Stonleigh

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

812 Stoneleigh Road

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Years:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Industrial Relations

Manager

16b. Kind of Business/Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

Clement Daniel Zweier

18. Mother's Name (First, Middle, Maiden Surname)

Annie Isabelle Jarrett

19a. Informant's Name/Relationship (Type, Print)

Mr. Donald H. Smith (Son-in-law)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13711 Princess Anne Way, Phoenix, MD 21131
Springfield Mennonite Ch Cem. 8/3 Quakertown, Maryland

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Springfield Mennonite Ch Cem. 8/3 Quakertown, Maryland

21. Signature of Funeral Service Licensee

Martin D. Lawson

22. Name and Address of Facility

Mitchell-Wiedefeld Home
6500 York Road, Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardio-Renal Vascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? ☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charles F. O'Donnell, M.D.

29c. License number

D-09383

29d. Date signed (Month, Day, Year)

July 31, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles F. O'Donnell, M.D., 111 Hamlet Hill Road, Baltimore, MD 21210

31. Date filed (Month, Day, Year)

AUG 05 1996

Julia Davidson-Rodriguez

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23080

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frances H. Zimmerman				2. Date of Death Month August Day 1 Year 1996		3. Time of Death 2:40 A.M.	
	4a. Facility Name (If not institution, give street and number) 805 Starbit Court				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore County	
Funeral Director	5. Social Security Number 196 18 6550		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 3, 1914	9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residence of Decedent				10a. State Maryland		10b. County N/A	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 3714 - 10th Street		10f. Zip Code 21225		10g. Citizen of What Country? U.S.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Second (0-12) 12th College (1-4or 5+)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Charles Haker				18. Mother's Name (First, Middle, Maiden Surname) Maggie G. Sterner			
	19e. Informant's Name/Relationship (Type, Print) William D. Zimmerman				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 805 Starbit Court Baltimore, Maryland 21286			
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park		Date 8/3/96		20c. Location - City or Town, State Glen Burnie, Maryland	
	21. Signature of Funeral Service Licensee <i>Richard C. Davis</i>				22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225			
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Metastatic large Carcinoma Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28e. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>Dani M. Hahn MD</i>				29c. License number 020396		29d. Date signed (Month, Day, Year) August 2, 1996	
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dani M. Hahn 5801 Loch Raven Blvd Baltimore Md 21239							
	31. Date filed (Month, Day, Year) AUG 05 1996		32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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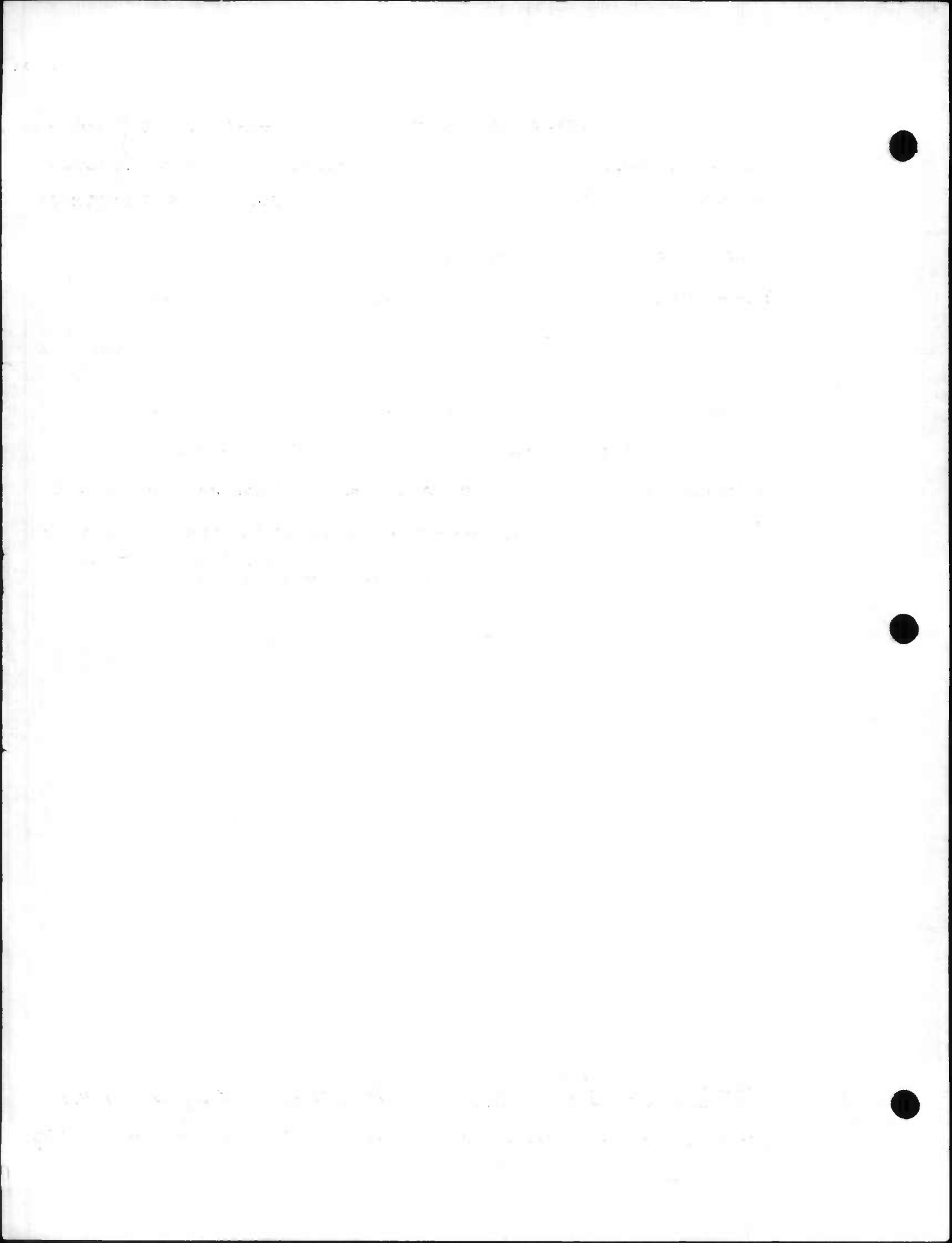
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23081

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ERwood ELZIE Avery				2. Date of Death Month Day Year July 22 1996		3. Time of Death 1146		
	4a. Facility Name (If not institution, give street and number) Annie Arundel Gen Hosp.				4b. City, Town, or Location of Death Annapolis		4c. County of Death AA		
Funeral Director	5. Social Security Number 212-03-0145		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec 23 1906	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Shadyside		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 6147 Shadyside Road				10f. Zip Code 20764		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner/Operator		16b. Kind of Business/Industry Utility Contractor/ Sewage				
	17. Father's Name (First, Middle, Last) Salem Walter Avery				18. Mother's Name (First, Middle, Maiden Surname) Mary Ann Crandell				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Olive Elizabeth Avery-Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6147 Shadyside Road Shadyside, Maryland 20764				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Crematory		20c. Location - City or Town, State Brentwood, Maryland		20d. Date 7/23/96		
	21. Signature of Funeral Service Licensee <i>Donald L. Lytle</i>				22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401				
	Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
	Immediate Cause (Final disease or condition resulting in death) a. Cardio Respiratory Failure 7 days Due to (or as a consequence of): b. Intra Cerebral Hemorrhage Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) Jul 15/96		28b. Time of Injury AM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Fell & hit head	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home				28f. Location (Street and Number or Rural Route Number, City or Town, State) Shady Side, MD			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>William P. Jones MD</i> Deputy		29c. License number D06054		29d. Date signed (Month, Day, Year) July 22 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William P. Jones, MD 695 America 21035									
31. Date filed (Month, Day, Year) JUL 23 1996		32. Registrar's Signature <i>Jill Davidson-Randall</i>							

Baltimore, Maryland 21215-0020

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Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23082

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HENRY A. AUSTIN, SR.				2. Date of Death Month Day Year July 14, 1996		3. Time of Death 6:45 P.M.		
	4a. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER				4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 410-03-0167		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 20, 1916		
	9. Birthplace (State or Foreign Country) Nashville, TN								
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits 1 Yes 2 No				
	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Cheverly				
	10e. Street and Number 3117 Parkway				10f. Zip Code 20785		10g. Citizen of What Country? United States		
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retired Printer		16b. Kind of Business/Industry Government				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Unknown				18. Mother's Name (First, Middle, Maiden Surname) Ollie B. Worley				
	19a. Informant's Name/Relationship (Type, Print) Sidney Adams - Son-In-Law				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3117 Parkway, Cheverly, Maryland 20785				
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		Date 7/17/96		20c. Location - City or Town, State Landover, Maryland		
	21. Signature of Funeral Service Licensee <i>John T. Stewart III</i>				22. Name and Address of Facility STEWART FUNERAL HOME, Inc. 4001 Benning Road, N. E., Washington, D. C.				
	23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. Metastatic Carcinoma (Source unknown) Due to (or as a consequence of): b. Metabolic Acidosis Due to (or as a consequence of): c. Sepsis Due to (or as a consequence of): d. Pneumonia				Approximate Interval Between Onset and Death unknown 3 days 3 days 3 days				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Prostate Cancer						23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
24a. Was an autopsy performed? 1 Yes 2 No						24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Stephen Jay Katz, MD</i>		29c. License number 038687		29d. Date signed (Month, Day, Year) 7/15/96			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) STEPHEN JAY KATZ, MD PGHC Cheverly, MD									
31. Date filed (Month, Day, Year) JUL 19 1996		32. Registrar's Signature <i>Jahia Davidson-Randall</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. The first part of the report is a general
description of the project and its objectives.
2. The second part is a detailed description of the
methodology used in the study.
3. The third part is a description of the results
of the study.
4. The fourth part is a discussion of the results
and their implications.
5. The fifth part is a conclusion and a list of
references.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23083

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret L Anderson				2. Date of Death Month July Day 14 Year 1996		3. Time of Death 9:12 pm	
	4a. Facility Name (If not Institution, give street and number) Washinton Adventist Hospital				4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery County	
Funeral Director	5. Social Security Number 242-63-8365	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 54 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month July Day 22 Year 1941		9. Birthplace (State or Foreign Country) Pitt Co., NC
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County Prince Georges		10c. City, Town or Location Takoma Park			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 6419 5th Avenue				10f. Zip Code 20912		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) 			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeper			16b. Kind of Business/Industry Hyattsville Court	
	17. Father's Name (First, Middle, Last) William Oscar Horne				18. Mother's Name (First, Middle, Maiden Surname) Lossie Battle			
	19a. Informant's Name/Relationship (Type, Print) Gloria Anderson/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6419 5th Ave. Takoma Park, MD 20912			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hamilton Burial Garden		Date 7-17-96		20c. Location - City or Town, State Wilson, NC	
	21. Signature of Funeral Service Licensee Alex S. Pope Jr.				22. Name and Address of Facility 5538 Marlboro Pike Forestville, MD 20747			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ventricular Fibrillation Due to (or as a consequence of): b. Congestive Heart Failure Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury et Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier [Signature]				29c. License number D 23177		29d. Date signed (Month, Day, Year) 7/15/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIO D. BELLEDONNE, MD 121 CONGRESSIONAL LN 205 ROCKVILLE								
31. Date filed (Month, Day, Year) JUL 17 1996				32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0020

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Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23084

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Nellie Irene Attick

2. Date of Death

Month
July

Day
11,

Year
1996

3. Time of Death

8:00 am

4a. Facility Name (If not Institution, give street and number)

190-29770 Oak Road

4b. City, Town, or Location of Death

Mechanicsville

4c. County of Death

St. Mary's

Funeral
Director

5. Social Security Number

579-10-0792

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 6, 1917

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Mechanicsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

190-29770 Oak Road

10f. Zip Code

20659

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Columbus Durrett McCauley

18. Mother's Name (First, Middle, Maiden Surname)

Eleanor Clements

19a. Informant's Name/Relationship (Type, Print)

Barbara Degutis / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10015 West Mill Pond Drive, Bishopsville, MD 21813

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cemetery 7/15/1996

Date

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Francis Gasch - Brady

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

b. Mitral Regurgitation

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☒ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John Janning M.D.

29c. License number

D27189

29d. Date signed (Month, Day, Year)

7/11/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZAHIR YOUSAF, P.O. BOX 1289, WALDORF, M.D 20604

31. Date filed (Month, Day, Year)

JUL 16 1996

32. Registrar's Signature

John Janning

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23085

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM DORSEY Brown				2. Date of Death Month July Day 19 Year 1996		3. Time of Death 10:50a.m.																											
	4a. Facility Name (If not institution, give street and number) Memorial Hospital at Easton				4b. City, Town, or Location of Death Easton		4c. County of Death Talbot																											
Funeral Director	5. Social Security Number 220-52-0778		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 47 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUNE 4 1949																											
	9. Birthplace (State or Foreign Country) MARYLAND																																	
Usual Residence of Decedent																																		
10a. State MARYLAND		10b. County TALBOT		10c. City, Town or Location EASTON			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																											
10e. Street and Number 406 MOTON STREET APT. 106				10f. Zip Code 21601		10g. Citizen of What Country? US																												
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK																											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CHEF COOK			16b. Kind of Business/Industry TIDEWATER INN																											
17. Father's Name (First, Middle, Last) EARL BROWN				18. Mother's Name (First, Middle, Maiden Surname) GERTRUDE FLAMER																														
19a. Informant's Name/Relationship (Type, Print) OLETHEA C. JOHNSON (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 220 PORT STREET EASTON, MD. 21601																														
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) SANDTOWN CEMETERY		Date 7/27/96		20c. Location - City or Town, State DENTON, MD.																										
21. Signature of Funeral Service Licensee <i>Lang D Reese</i>				22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401																														
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																		
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td><i>Gram Negative Sepsis</i></td> <td><i>2° to</i></td> <td rowspan="4"> Approximate Interval Between Onset and Death <i>7d</i> <i>4m</i> </td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td><i>Immune suppression</i></td> <td><i>2° to Rx for</i></td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td><i>Acute Myelogenous Leukemia</i></td> <td></td> <td></td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<i>Gram Negative Sepsis</i>	<i>2° to</i>	Approximate Interval Between Onset and Death <i>7d</i> <i>4m</i>	Due to (or as a consequence of):			b.	<i>Immune suppression</i>	<i>2° to Rx for</i>	Due to (or as a consequence of):			c.	<i>Acute Myelogenous Leukemia</i>			Due to (or as a consequence of):				d.			
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c.	<i>Acute Myelogenous Leukemia</i>																																	
Due to (or as a consequence of):																																		
d.																																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																												
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																												
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																												
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																														
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred																										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																														
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																		
29b. Signature and title of certifier <i>William H Wood MD</i>				29c. License number <i>1208715</i>		29d. Date signed (Month, Day, Year) <i>7/20/96</i>																												
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) WILLIAM H. WOOD, MD 506 IDLEWILD AVE. EASTON, MD. 21601																																		
31. Date filed (Month, Day, Year) JUL 22 1996		32. Registrar's Signature <i>Julia Davidson-Rendall</i>																																

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Amended #1 att

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23086
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Caitlin Dunleavy Bloom</u>						2. Date of Death Month <u>July</u> Day <u>19</u> Year <u>1996</u>		3. Time of Death <u>1404</u>												
	4a. Facility Name (If not institution, give street and number) <u>The Johns Hopkins Hospital</u>						4b. City, Town, or Location of Death <u>Baltimore City</u>		4c. County of Death <u>Baltimore City</u>												
Funeral Director	5. Social Security Number <u>217-21-1674</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>18</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>March 20, 1978</u>		9. Birthplace (State or Foreign Country) <u>Washington, DC</u>												
	Usual Residence of Decedent																				
10a. State <u>Maryland</u>		10b. County <u>Anne Arundel</u>		10c. City, Town or Location <u>Annapolis, Maryland 21401</u>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No													
10e. Street and Number <u>20 S. Cherry Grove Avenue</u>				10f. Zip Code <u>21401</u>		10g. Citizen of What Country? <u>United States</u>															
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>white</u>													
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4or 5+) <u></u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>student</u>			16b. Kind of Business/Industry														
17. Father's Name (First, Middle, Last) <u>Edward R. Bloom</u>						18. Mother's Name (First, Middle, Maiden Surname) <u>Jennie Dunleavy</u>															
19a. Informant's Name/Relationship (Type, Print) <u>Edward R. Bloom (father)</u>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>20 S. Grove Avenue, Annapolis, Maryland 21401</u>															
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Fort Lincoln Crematory</u>			Date <u>July 20, 1996</u>		20c. Location - City or Town, State <u>Brentwood, Maryland</u>													
21. Signature of Funeral Service Licensee <u>[Signature]</u>						22. Name and Address of Facility <u>John M. Taylor Funeral Home</u> <u>147 Duke of Gloucester Street, Annapolis, Maryland</u>															
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																					
<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>e. <u>Liver Failure</u></td> <td rowspan="4"> Approximate Interval Between Onset and Death <u>21401</u> </td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b. <u>Vasooocclusive Disease of the Liver</u></td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td></td> <td>c. <u>Hodgkin's Disease</u></td> <td><u>18 months</u></td> </tr> <tr> <td></td> <td>d. <u></u></td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e. <u>Liver Failure</u>	Approximate Interval Between Onset and Death <u>21401</u>	Due to (or as a consequence of):	b. <u>Vasooocclusive Disease of the Liver</u>	Due to (or as a consequence of):		c. <u>Hodgkin's Disease</u>	<u>18 months</u>		d. <u></u>	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e. <u>Liver Failure</u>	Approximate Interval Between Onset and Death <u>21401</u>																			
	Due to (or as a consequence of):																				
	b. <u>Vasooocclusive Disease of the Liver</u>																				
	Due to (or as a consequence of):																				
	c. <u>Hodgkin's Disease</u>	<u>18 months</u>																			
	d. <u></u>																				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Atrial Fibrillation, Cardiomyopathy,</u> <u>Adult Respiratory Distress Syndrome, Renal Failure</u>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown													
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred													
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>D47008</u>		29d. Date signed (Month, Day, Year) <u>July 19, 1996</u>															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>James J. Fehr MD The Johns Hopkins Hospital, Baltimore, MD.</u>																					
31. Date filed (Month, Day, Year) <u>JUL 23 1996</u>		32. Registrar's Signature <u>[Signature]</u>																			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23087

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alice North Boyer				2. Date of Death Month Day Year July 18 1996		3. Time of Death 11:45AM	
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 578-46-2964	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb 11 1916		9. Birthplace (State or Foreign Country) Virginia
	Usual Residence of Decedent							
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 2568 Misty Ridge Cove				10f. Zip Code 21401		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Assistant		16b. Kind of Business/Industry (Fannie Mae) Federal Government		
17. Father's Name (First, Middle, Last) John North				18. Mother's Name (First, Middle, Maiden Surname) Melvina Printz				
19a. Informant's Name/Relationship (Type, Print) Harold Norton Boyer-Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2568 Misty Ridge Cove Annapolis, Maryland 21401				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery 7/22/96		Date 7/22/96		20c. Location - City or Town, State Brentwood, Maryland		
21. Signature of Funeral Service Licensee <i>James H. Smith</i>				22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Fulminant Bilateral Pneumonia</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 1 week
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Pulmonary Fibrosis</i> <i>Smoking in Part</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>John M. Taylor</i> MD		29c. License number D32654		29d. Date signed (Month, Day, Year) July 18, 1996
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) John Serlemitsos MD 1509 Ritchie Highway, Arnold, MD 21012								
31. Date filed (Month, Day, Year) JUL 23 1996		32. Registrar's Signature <i>Julia Davidson-Randall</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23088

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELEANORA V BOUCHAL				2. Date of Death Month July Day 22 Year 1996		3. Time of Death 3:45 a.m.	
	4a. Facility Name (If not institution, give street and number) Memorial Hospital at Easton				4b. City, Town, or Location of Death Easton		4c. County of Death Talbot	
Funeral Director	5. Social Security Number 213-28-6502		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 17 1903	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 2732 Gingerview Lane				10f. Zip Code 21401		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home		
17. Father's Name (First, Middle, Last) William Frederick Welch					18. Mother's Name (First, Middle, Maiden Surname) Mary Booker			
19a. Informant's Name/Relationship (Type, Print) Joseph H. Bouchal, Jr.-Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2732 Gingerview Lane Annapolis, Maryland 21401				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Memorial Cemetery 7/24/96 Annapolis, Maryland			Date		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee <i>Donald S. Taylor</i>				22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Right lower lobe Pneumonia Due to (or as a consequence of): b. Aspiration Due to (or as a consequence of): c. Dementia of Alzheimer's Type Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate interval Between Onset and Death 3d 3d Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Drake's Melancholia II Hyperparathyroidism						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier William H. Wood, Jr. MD		29c. License number D08715		29d. Date signed (Month, Day, Year) 7/22/96				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William H. Wood, Jr., M.D. 506 Idlewild Avenue Easton, MD 21601								
31. Date filed (Month, Day, Year) JUL 23 1996		32. Registrar's Signature <i>John Davidson-Randall</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23089

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ABDUL AZIZ BAIG

2. Date of Death

July 09 1996

3. Time of Death

1155pm

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

578-92-3666

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

4-12-25

9. Birthplace (State or Foreign Country)

India

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Springs

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9710 Marshall Ave

10f. Zip Code

20901

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Indian

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Telephone supervisor

16b. Kind of Business/Industry

Communications

17. Father's Name (First, Middle, Last)

Habib Ullah

18. Mother's Name (First, Middle, Maiden Surname)

Mukhdar Begun

19a. Informant's Name/Relationship (Type, Print)

Abdul Waheed Baig

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9710 Marshall Ave, Silver Spring, Md. 20901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

George Washington

Date

7-11-96

20c. Location - City or Town, State

Adelphi, Md.

21. Signature of Funeral Service Licensee

Pamela de Mata

22. Name and Address of Facility

Universal Mortuary Inc.
11 Kennedy St, N.W. Washington, D.C.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Asystole / Hypotension

Approximate Interval Between Onset and Death

10 min

Due to (or as a consequence of):

b. Intracerebral bleed

1 day

Due to (or as a consequence of):

c. Brain tumor (metastatic)

Due to (or as a consequence of):

d. prostatic cancer

1 yr

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Rashid Bayhui Naini

29c. License number

D39372

29d. Date signed (Month, Day, Year)

July 9th 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

RASHID BAYHUI - NAINI

344 UNIVERSITY BLVD WEST

31. Date filed (Month, Day, Year)

JUL 19 1996

32. Registrar's Signature

Julia D. [Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

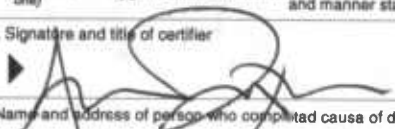
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23090

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RICHARD PAUL BAKER				2. Date of Death Month JULY Day 14 Year 1996		3. Time of Death 9:50 AM		
	4a. Facility Name (If not institution, give street and number) 12756 MIDWOOD LANE				4b. City, Town, or Location of Death BOWIE		4c. County of Death PRINCE GEORGES		
Funeral Director	5. Social Security Number 579 46 8344	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 24, 1935		9. Birthplace (State or Foreign Country) Washington D.C.	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Bowie			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10a. Street and Number 12756 Midwood Lane			10f. Zip Code 20715		10g. Citizen of What Country? United States			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 58-60		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+) 		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary/Treasure		16b. Kind of Business/Industry Union				
	17. Father's Name (First, Middle, Last) Thomas James Baker				18. Mother's Name (First, Middle, Maiden Surname) Mildred Barber				
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Linda L. Murphy Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12204 Millstream Drive Bowie Maryland 20715				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Memorial Gardens		Date 7/19/96		20c. Location - City or Town, State Davidsonville Md.		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier  Ann Dixon M.D.				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 14, 1996		
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ann Dixon M.D. 111 Penn Street, Baltimore, Maryland 21201								
	31. Date filed (Month, Day, Year) JUL 17 1996				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

96 23091

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Clarence T Barbee				2. DATE OF DEATH MONTH 7 DAY 11 YEAR 96		3. TIME OF DEATH 1:58p	
4. SOCIAL SECURITY NUMBER 579-16-7937		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) 2 19 13	
8. BIRTHPLACE (State or Foreign Country) Adairville KY				9a. FACILITY NAME (If not Institution, give street and number) Regency Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Forestville	
9c. COUNTY OF DEATH Prince Georges				10a. STATE Maryland		10b. COUNTY Prince Georges	
10c. CITY, TOWN OR LOCATION Suitland Maryland				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 5310 Auth Road	
10f. ZIP CODE 20746				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 8+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Postal Carrier		16b. KIND OF BUSINESS/INDUSTRY US Postal Service	
17. FATHER'S NAME (First, Middle, Last) Zelma Barbee				18. MOTHER'S NAME (First, Middle, Maiden Surname) Minnie Mae Burks			
19a. INFORMANT'S NAME (Type/Print) Ethel Barbee/Wife				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5310 Auth Road Suitland, Maryland 20746			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resurrection Cemetery 7/15		20c. LOCATION — City or Town, State Clinton, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Alexander S. Pope Funeral Homes 5538 Marlboro Pike Forestville, MD 20747			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC CARCINOMA OF PROSTATE DUE TO (OR AS A CONSEQUENCE OF): ANEMIA DUE TO (OR AS A CONSEQUENCE OF): RENAL INSUFFICIENCY DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER (FOR DR. FARSON)				29c. LICENSE NUMBER D-34525		29d. DATE SIGNED (Month, Day, Year) 07-12-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Page, Print) S J. Rao, MD; 4000 Mitchellville Road; #220; Bowie-MD-20716							
31. DATE FILED (Month, Day, Year) JUL 17 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96-3904-033

96-150

B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23092

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

QUINTIN

BUTLER

2. Date of Death

Month JULY Day 14, Year 1996

3. Time of Death

0217 AM

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES HOSPITAL CENTER E.R.

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

578-02-4454

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

30 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month, Day, Year
June 7 1966

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

N/A

10b. County

N/A

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2586 Naylor Road #102

10f. Zip Code

20020

10g. Citizen of What Country?

United States

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Landscaper

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Vincente J. Butler

18. Mother's Name (First, Middle, Maiden Surname)

Brenda Owens

19a. Informant's Name/Relationship (Type, Print)

Brenda Butler/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5002 Lee Jay Drive #302 Capital Hgts, MD 20743

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln Memorial Cem

Date

7/19

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

Alexander S. Pope Jr.

22. Name and Address of Facility

Alexander S. Pope Funeral Homes

5538 Marlboro Pike Forestville, MD. 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gunshot wounds of chest
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☒ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

7-14-96

28b. Time of Injury

0136 M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

Subject shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Ritchie Rd. Capital Hgts.

29a. Certifier (Check only one)

☐ Certifying Physician☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. A. Dixon

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

JULY 14, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 19 1996

32. Registrar's Signature

Julia Anderson-Randall

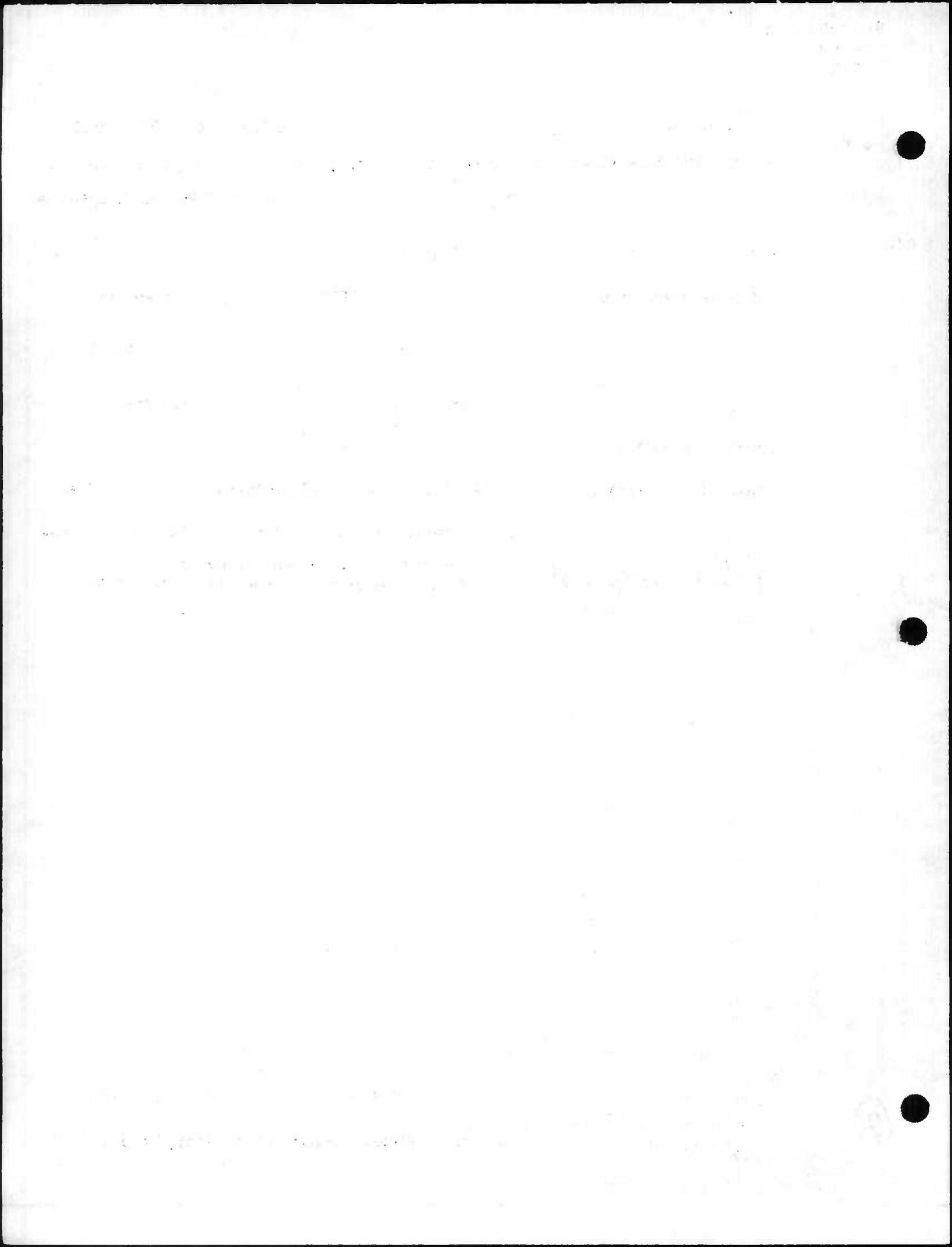
State
RegistrarBaltimore, Maryland 21215-0020
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23093

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carlton L. Brodie				2. Date of Death Month Day Year 7 9 1996		3. Time of Death 12:30 AM		
	4a. Facility Name (If not institution, give street and number) 5415 76th Avenue				4b. City, Town, or Location of Death Hyattsville		4c. County of Death Prince Georges		
Funeral Director	5. Social Security Number 239-26-3850		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 7 31 1925	9. Birthplace (State or Foreign Country) North Carolina	
	10a. State MD.				10b. County Prince Georges		10c. City, Town or Location Hyattsville		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10a. Street and Number 5415 76th Avenue				10f. Zip Code 20784		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2nd Collage (1-4or 5+) College				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Private Companies		
	17. Father's Name (First, Middle, Last) Edward Brodie				18. Mother's Name (First, Middle, Maiden Summa) Viola Brodie				
	19a. Informant's Name/Relationship (Type, Print) Violet Porter daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5415 76th Avenue Hyattsville Md. 20784				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glenwood Cemetery		20c. Location - City or Town, State 7-13 Washington DC				
	21. Signature of Funeral Service Licensee J. P. Marshall				22. Name and Address of Facility Marshall's Funeral Home Inc 4217 9th Street, N.W. Washington, D. C. 20011				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Small cell lung cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier Anthony G. Arcenas				29c. License number DC 20459		29d. Date signed (Month, Day, Year) July 12, 1996		
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anthony G. Arcenas, M.D., 50 Irving St. N.W. Washington, DC 20422								
	31. Date filed (Month, Day, Year) JUL 15 1996		32. Registrar's Signature John Davidson Randall						

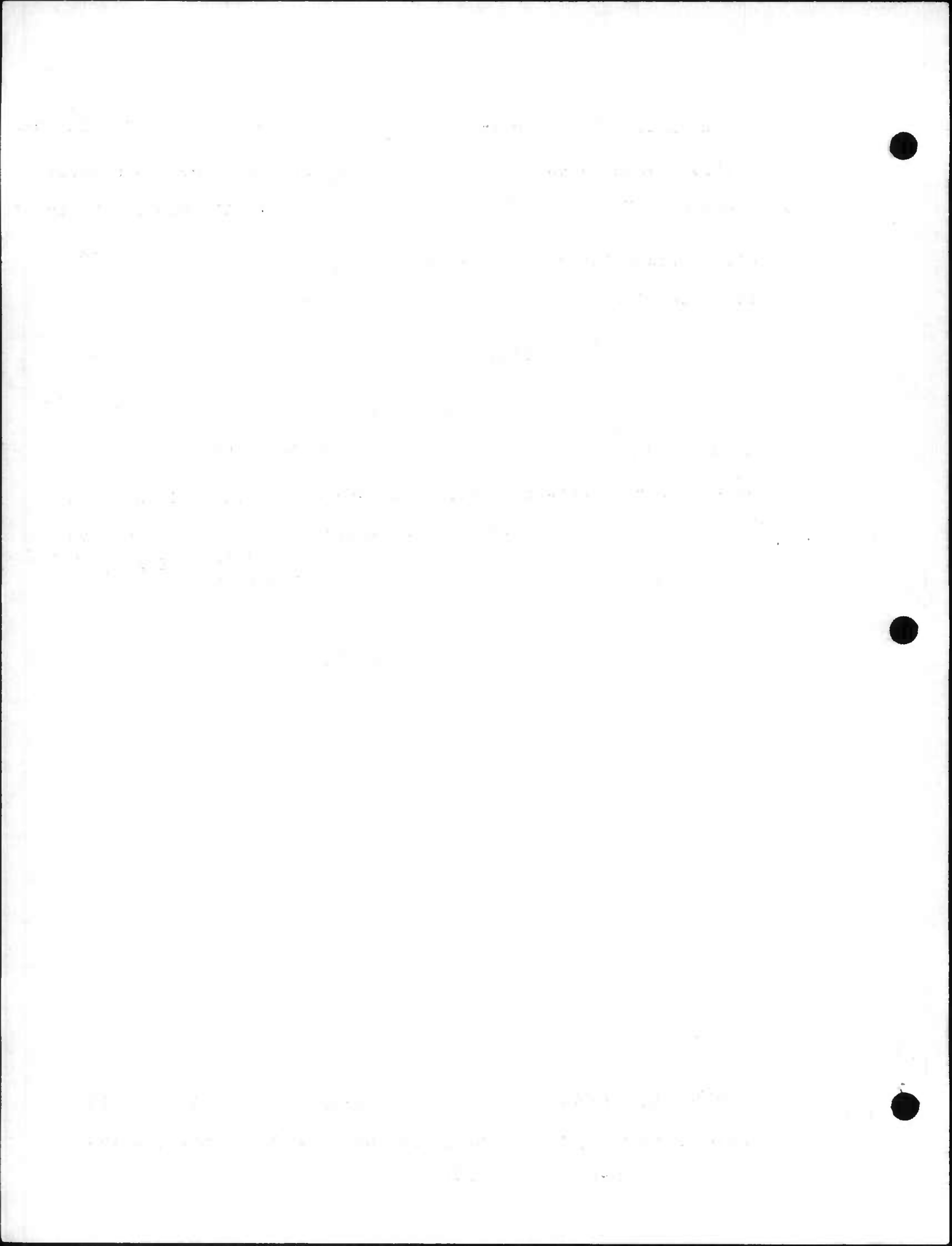
Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23094

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Michael STEPHEN Chappars</i>				2. Date of Death Month <i>July</i> Day <i>23</i> Year <i>1996</i>		3. Time of Death <i>6:12pm</i>	
	4a. Facility Name (If not institution, give street and number) <i>Southern MD Hospital Center</i>				4b. City, Town, or Location of Death <i>Clinton</i>		4c. County of Death <i>Prince George's</i>	
Funeral Director	5. Social Security Number <i>217-44-0649</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>92</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Oct 26 1903</i>	
	10a. State <i>Maryland</i>		10b. County <i>Prince George's</i>		10c. City, Town or Location <i>Brandywine</i>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <i>21611 Meadow Wood Lane</i>				10f. Zip Code <i>20613</i>		10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4+</i> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Geologist</i>		16b. Kind of Business/Industry <i>US Government</i>		
17. Father's Name (First, Middle, Last) <i>George Chappars</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Maria Chimonakov Chappars</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Mary E. Landon-Whitlow (Daughter)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>21611 Meadow Wood La Brandywine, MD 20613</i>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Metropolitan</i>		Date <i>7-26-96</i>		20c. Location - City or Town, State <i>Alexandria, VA</i>
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>J.H. Eberwein Mortuary 4433 White Pls La White Pls, MD 20695</i>				
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line. <i>Coronary Artery Disease</i>								Approximate Interval Between Onset and Death
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <i>D30135</i>		29d. Date signed (Month, Day, Year) <i>July 24, 1996</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Kenneth Larsen M.D. SMHC 7503 Sunnyside Rd, Clinton, MD</i>								
31. Date filed (Month, Day, Year) <i>JUL 25 1996</i>				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. The first part of the report deals with the general situation of the country and the progress of the work during the year.

2. The second part of the report deals with the results of the work during the year and the progress of the work during the year.

3. The third part of the report deals with the results of the work during the year and the progress of the work during the year.

4. The fourth part of the report deals with the results of the work during the year and the progress of the work during the year.

5. The fifth part of the report deals with the results of the work during the year and the progress of the work during the year.

6. The sixth part of the report deals with the results of the work during the year and the progress of the work during the year.

7. The seventh part of the report deals with the results of the work during the year and the progress of the work during the year.

8. The eighth part of the report deals with the results of the work during the year and the progress of the work during the year.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23095

Certificate of Death

Reg. No.

1. Decedent's Name (First, Middle, Last) <i>PRISCILLA COLBERT</i>		2. Date of Death Month <i>JULY</i> Day <i>16</i> Year <i>1996</i>		3. Time of Death <i>6 am</i>											
4a. Facility Name (If not institution, give street and number) <i>SOUTHERN MARYLAND HOSPITAL</i>		4b. City, Town, or Location of Death <i>CLINTON</i>		4c. County of Death <i>PRINCE GEORGES</i>											
5. Social Security Number <i>234-56-2065</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>61</i> Yrs.											
8. Date of Birth (Month, Day, Year) <i>Nov 23 1934</i>		9. Birthplace (State or Foreign Country) <i>Gary West VA</i>													
Usual Residence of Decedent															
10a. State <i>MD</i>		10b. County <i>Prince Georges</i>		10c. City, Town or Location <i>Fort Washington, Maryland</i>											
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <i>3716 Copperville Way</i>		10f. Zip Code <i>20744</i>											
10g. Citizen of What Country? <i>United States</i>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:											
13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>													
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>College</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Garment Supervisor</i>		16b. Kind of Business/Industry <i>Clothing</i>											
17. Father's Name (First, Middle, Last) <i>Walter Wilson</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Hattie Foster</i>													
19a. Informant's Name/Relationship (Type, Print) <i>Theresa Carethers/Daughter</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3716 Copperville Way Fort Washington, MD 20744</i>													
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Lincoln Memorial Cem.</i>		20c. Location - City or Town, State <i>Landover, Md.</i>											
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <i>Alexander S. Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 20747</i>													
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td><i>Dehydration</i></td> <td rowspan="4"> Approximate Interval Between Onset and Death <i>7 days</i> <i>6 months</i> <i>1 yr</i> </td> </tr> <tr> <td>b.</td> <td><i>Terminal Cancer of Colon with</i></td> </tr> <tr> <td>c.</td> <td><i>Metastasis to Liver during 18 mos</i></td> </tr> <tr> <td>d.</td> <td><i>Thyroid cancer</i></td> </tr> </table>						Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	<i>Dehydration</i>	Approximate Interval Between Onset and Death <i>7 days</i> <i>6 months</i> <i>1 yr</i>	b.	<i>Terminal Cancer of Colon with</i>	c.	<i>Metastasis to Liver during 18 mos</i>	d.	<i>Thyroid cancer</i>
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	<i>Dehydration</i>	Approximate Interval Between Onset and Death <i>7 days</i> <i>6 months</i> <i>1 yr</i>												
	b.	<i>Terminal Cancer of Colon with</i>													
	c.	<i>Metastasis to Liver during 18 mos</i>													
	d.	<i>Thyroid cancer</i>													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown															
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>											
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)											
28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. Signature and title of certifier <i>[Signature]</i> <i>Attending</i>		29c. License number <i>D-24535</i>		29d. Date signed (Month, Day, Year) <i>7/16/96</i>											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>LAKMI DEWANI 7700 OLD BRANCH Avenue CLINTON MARYLAND 20735</i>															
31. Date filed (Month, Day, Year) <i>JUL 17 1996</i>		32. Registrar's Signature <i>[Signature]</i>													

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

15 0/15

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23096

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kenneth Howard Campbell			2. Date of Death Month Day Year July 5, 1996		3. Time of Death 4:37 AM	
	4a. Facility Name (If not institution, give street and number) Prince George's Doctor's Hospital			4b. City, Town, or Location of Death Lanham		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 191-26-0881		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) March 30, 1933
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Lanham
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 7203 Sunrise Drive		10f. Zip Code 20706	
10g. Citizen of What Country? United States of America		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Korean		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Butcher		16b. Kind of Business/Industry Food Service	
17. Father's Name (First, Middle, Last) Howard Campbell			18. Mother's Name (First, Middle, Maiden Surname) Bessie (Unavailable)				
19a. Informant's Name/Relationship (Type, Print) Janie Stinson Campbell - Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7203 Sunrise Drive Lanham, Maryland 20706				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Stinson Family Cemetery		20c. Location - City or Town, State 7-7-96 Buckingham Co., VA		
21. Signature of Funeral Service Licensee Howard H. Cason			22. Name and Address of Facility Robinson Funeral Home P.O. Box 6 Appomattox, Virginia 24522				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Respiratory Distress Syndrome Due to (or as a consequence of): Sepsis Cause of Injury Due to (or as a consequence of):			Approximate Interval Between Onset and Death				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. History of Lymphoma. Chronic Obstructive Pulmonary Disease			23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier Vicken Poochikian, M.D.		29c. License number D34722		29d. Date signed (Month, Day, Year) 7-5-96
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vicken Poochikian, M.D. 5632 Annapolis Road Bladensburg, Maryland			31. Date filed (Month, Day, Year) JUL 15 1996				
32. Registrar's Signature Julia Anderson-Randall			State Registrar				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

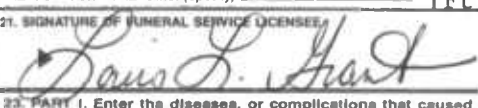

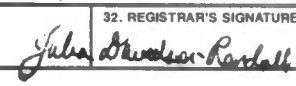
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

96 23097

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JAMES (NMN) DARGAVEL				2. DATE OF DEATH MONTH DAY YEAR JULY 5, 1996		3. TIME OF DEATH 7:46 A.	
4. SOCIAL SECURITY NUMBER 577-48-4812		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 25 1914	
9a. FACILITY NAME (If not institution, give street and number) Prince Georges Hospital Center				9b. CITY, TOWN OR LOCATION OF DEATH Cheverly		9c. COUNTY OF DEATH Prince Georges	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Hyattsville		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5805 42nd Avenue				10f. ZIP CODE 20781		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer		16b. KIND OF BUSINESS/INDUSTRY Property Management			
17. FATHER'S NAME (First, Middle, Last) James Dargavel				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jessie McLean			
19a. INFORMANT'S NAME (Type/Print) Alex C. Dargavel				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5306 Riga Str. Clinton Md. 20735			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery 7-8-96		20c. LOCATION — City or Town, State Brentwood, Maryland		22. NAME AND ADDRESS OF FACILITY Ft. Lincoln F.H. Inc. 3401 Bladensburg Rd. Brentwood Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. CARDIOPULMONARY ARREST							
DUE TO (OR AS A CONSEQUENCE OF):							
b. POSSIBLE ACUTE MYOCARDIAL INFARCTION							
DUE TO (OR AS A CONSEQUENCE OF):							
c. CORONARY ARTERY DISEASE							
DUE TO (OR AS A CONSEQUENCE OF):							
d.							
Approximate Interval Between Onset and Death							
UNKNOWN							
UNKNOWN							
UNKNOWN							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DIABETES MELLITUS							
END STAGE RENAL DISEASE							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D18089		29d. DATE SIGNED (Month, Day, Year) 7/11/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Steven M. Pollak, M.D. 7525 Greenway Center Drive #313 Greenbelt, MD 20770							
31. DATE FILED (Month, Day, Year) JUL 18 1996		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23098

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dennis Downey				2. Date of Death Month Day Year July 14 1996		3. Time of Death 4:42 PM	
	4a. Facility Name (If not institution, give street and number) Doctors' Community Hospital				4b. City, Town, or Location of Death Lanham		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 090 40 4964	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 29, 1948		9. Birthplace (State or Foreign Country) New York
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Bowie			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10a. Street and Number 13207 Chestnut Drive			10f. Zip Code 20720		10g. Citizen of What Country? United States		
	11. Marital Status 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher		16b. Kind of Business/Industry U.S. Government			
	17. Father's Name (First, Middle, Last) William E. Downey				18. Mother's Name (First, Middle, Maiden Surname) Patricia Lloyd			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Nancy R. Downey Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13207 Chestnut Drive Bowie Maryland 20720				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 7/19/96		20c. Location - City or Town, State Alexandria Virginia	
	21. Signature of Funeral Service Licensee Robert E. Evans Pres			22. Name and Address of Facility Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>HEPATIC FAILURE</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate interval Between Onset and Death							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CIRRHOSIS, COAGULOPATHY</u> <u>NUMER FAILURE</u>							
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		26a. Date of Injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Michael M. Adams MD		29c. License number D19220		29d. Date signed (Month, Day, Year) 7-15-96	
	30. Name and address of person who completed cause of death (item 23a) (Type, Print) 9811 Mallard Drive Laurel Md 20708							
31. Date filed (Month, Day, Year) JUL 17 1996				32. Registrar's Signature Julia Anderson-Randall				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

At 10:00 AM

1. 1st Lt. J. H. ...

2. 2nd Lt. J. H. ...

3.

4. 1st Lt. J. H. ...

5. 2nd Lt. J. H. ...

6. 3rd Lt. J. H. ...

7. 4th Lt. J. H. ...

8. 5th Lt. J. H. ...

9. 6th Lt. J. H. ...

10. 7th Lt. J. H. ...

11. 8th Lt. J. H. ...

12. 9th Lt. J. H. ...

13. 10th Lt. J. H. ...

14. 11th Lt. J. H. ...

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23099

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) MAXIMO BARRIOS ESTRADA				2. Date of Death Month JULY Day 17 Year 1996		3. Time of Death 4:04 P.M.	
4a. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL				4b. City, Town, or Location of Death CHEVERLY		4c. County of Death PRINCE GEORGES	
5. Social Security Number NONE		6. Sex 129 M 20 F		7. Age (In yrs. last birthday) 25 Yrs.		8. Date of Birth (Month, Day, Year) 9-30-70	
9. Birthplace (State or Foreign Country) Guatemala							

Funeral
Director

To Be Completed by Funeral Director

Usual Residence of Decedent							
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Wheaton		10d. Inside City Limits 100 Yes 200 No	
10a. Street and Number 12022 Centerhill Street				10f. Zip Code 20902		10g. Citizen of What Country? Guatemala	
11. Marital Status 100 Never Married 200 Married 300 Widowed 400 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 100 Yes 200 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 100 Yes 200 No Specify: Central America		14. Race - American Indian, Black, White, etc. Specify: Hispanic	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Landscaping		16b. Kind of Business/Industry Gardening	
17. Father's Name (First, Middle, Last) Isaac Estrada				18. Mother's Name (First, Middle, Maiden Surname) Carmelina Barrios			
19a. Informant's Name/Relationship (Type, Print) Abraham Barrios (Brother)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12022 Centerhill St. Wheaton, Maryland 20902			
20a. Method of Disposition 100 Burial 200 Cremation 300 Removal from State 400 Donation 500 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mazatenango, Guatemala		20c. Location - City or Town, State Guatemala		20d. Date 7/23/96	
21. Signature of Funeral Service Licensee Asper Hoch				22. Name and Address of Facility PRICED-LESS FUNERAL SERVICE P.O. BOX 30012 WASHINGTON, D.C. 20030			

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Causa (Final disease or condition resulting in death) a. Multiple Gun Shot Wounds Due to (or as a consequence of):				Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? 100 Yes 200 No				26. Place of Death (Check only one) Hospital: 100 Inpatient 200 ER/Outpatient 300 DOA Other: 400 Nursing Home 500 Residence 600 Other (Specify)	
27. Manner of Death 100 Natural 200 Accident 300 Suicide 400 Homicide 500 Pending Investigation 600 Could not be determined		28a. Date of Injury (Month, Day, Year) 7-17-96		28b. Time of Injury 0430 M	
		28c. Injury at Work? 100 Yes 200 No		28d. Describe how injury occurred Subject shot.	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Residence		28f. Location (Street and Number or Rural Route Number, City or Town, State) 2016 Ogborne St	
29a. Certifier (Check only one) 100 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 200 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier [Signature]		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 18, 1996	
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) JUL 19 1996		32. Registrar's Signature [Signature]			

State
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23100

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Philip Eisenberg

2. Date of Death

Month Day Year
July 13 1996

3. Time of Death

3:30 P.M.

4a. Facility Name (If not institution, give street and number)

Manor Care Fernwood

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

052-05-3340

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
12-13-17

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State
Maryland10b. County
Montgomery10c. City, Town or Location
Bethesda

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10630 Montrose Avenue #203

10f. Zip Code

20814

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Author and Poet

16b. Kind of Business/Industry

Writing

17. Father's Name (First, Middle, Last)

Oscar Eisenberg

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Rubinfeld

19a. Informant's Name/Relationship (Type, Print)

Wendy Eisenberg - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

929 - 4th St., Apt. C, Santa Monica, Ca. 90403

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 7/14/96

Date

20c. Location - City or Town, State

Alexandria, Va.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Md. 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. cerebrovascular vascular accident

2 months

Due to (or as a consequence of):

b. atrial fibrillation

years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D34590

29d. Date signed (Month, Day, Year)

7-14-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10810 Connecticut Avenue, Kensington, MD 20895

31. Date filed (Month, Day, Year)

JUL 17 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

1. The first part of the paper is devoted to a general discussion of the problem.

2. In the second part, we consider the case of a single particle.

3. The third part is devoted to the case of a system of particles.

4. In the fourth part, we consider the case of a continuous medium.

5. The fifth part is devoted to the case of a system of continuous media.

6. In the sixth part, we consider the case of a single continuous medium.

7. The seventh part is devoted to the case of a system of continuous media.

8. In the eighth part, we consider the case of a single continuous medium.

9. The ninth part is devoted to the case of a system of continuous media.

10. In the tenth part, we consider the case of a single continuous medium.

11. The eleventh part is devoted to the case of a system of continuous media.

12. In the twelfth part, we consider the case of a single continuous medium.

13. The thirteenth part is devoted to the case of a system of continuous media.

14. In the fourteenth part, we consider the case of a single continuous medium.

15. The fifteenth part is devoted to the case of a system of continuous media.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23101

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KELLY A. ENGLAND		2. Date of Death Month JULY Day 09 Year 1996		3. Time of Death 7:11PM.
	4a. Facility Name (If not institution, give street and number) 1021 CATESBY TERR.		4b. City, Town, or Location of Death LANDOVER		4c. County of Death PRINCE GEORGES
Funeral Director	5. Social Security Number 324-80-8694	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 26 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) 08 11 69		9. Birthplace (State or Foreign Country) Iowa		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State Maryland		10b. County Prince George's
	10c. City, Town or Location Landover		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 1021 Catesby Terrace		10f. Zip Code 20785		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College		
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Private		
	17. Father's Name (First, Middle, Last) Karl Knutter		18. Mother's Name (First, Middle, Maiden Surname) Patricia Piskie		
	19e. Informant's Name/Relationship (Type, Print) Geoffrey England/Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1021 Catesby Terrace, Landover MD 20785		
	20e. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Memory Gardens		20c. Location - City or Town, State 7/15/96 Belvidere, Illinois
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road, Landover MD 20785		
Physician /Medical Examiner	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Seizure disorder Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequitentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day Year)		28b. Time of Injury M
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
State Registrar	29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 10, 1996
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE H. MCKIM 111 Penn Street, Baltimore, Maryland 21201				
	31. Date filed (Month, Day, Year) JUL 15 1996		32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

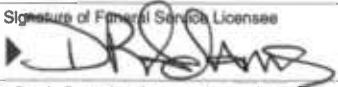
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23102

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Donald Theodore Fenton				2. Date of Death Month July Day 17 Year 1996				3. Time of Death 11 PM		
	4a. Facility Name (If not institution, give street and number) 12170 R4 Southern Maryland Blvd.				4b. City, Town, or Location of Death Dunkirk				4c. County of Death Calvert		
Funeral Director	5. Social Security Number 076-30-6153		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) June 25 1936		9. Birthplace (State or Foreign Country) New York		
	Usual Residence of Decedent				10e. State MD		10b. County Calvert		10c. City, Town or Location Dunkirk		
To Be Completed by Funeral Director	10d. inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 12170 R4 Southern Maryland Blvd.				10f. Zip Code 20754		
	10g. Citizen of What Country? United States				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assistant Manager				16b. Kind of Business/Industry Retail				17. Father's Name (First, Middle, Last) Ward H. Fenton		
	18. Mother's Name (First, Middle, Maiden Surname) Doris E. Brown				19a. Informant's Name/Relationship (Type, Print) Alice L. Fenton-Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12170 R4 Southern Maryland Blvd Dunkirk, MD 20754		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery 7/23/96 Cheltenham, Maryland				20c. Location - City or Town, State		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility John M. Taylor Funeral Home, Inc. Annapolis, Maryland (147 Duke of Gloucester St.)				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Metastatic prostate cancer Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Peter R. Graze M.D.				29c. License number 016364			
29d. Date signed (Month, Day, Year) 7/18/96				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Peter R. Graze, M.D., 900 Bestgate Rd. #300, Annapolis, MD 21401				31. Date filed (Month, Day, Year) JUL 24 1996			
32. Registrar's Signature Julia Davidson-Randall											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 23a or 23e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23103

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) INEZ FOX				2. Date of Death Month July Day 17 Year 1996		3. Time of Death 4:07 PM	
	4a. Facility Name (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL				4b. City, Town, or Location of Death CHINTON		4c. County of Death PRINCE GEORGE	
Funeral Director	5. Social Security Number 335-22-4166		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 11-27-23	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Oxon Hill			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 5103 Glassmanor Drive				10f. Zip Code 20745		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retail Sales Clerk			16b. Kind of Business/Industry Private	
17. Father's Name (First, Middle, Last) Charles Marshall				18. Mother's Name (First, Middle, Maiden Surname) Cora Pinkney				
19a. Informant's Name/Relationship (Type, Print) Audrey Stocks/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5103 Glassmanor Drive, Oxon Hill, Maryland 20745				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Pk.		Date 7/22/96		20c. Location - City or Town, State Landover, MD		
21. Signature of Funeral Service Licensee Nancy A. Perentis				22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, Maryland 20785				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute myocardial infarction Due to (or as a consequence of): b. Coronary artery disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death Immediate Yes
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. non insulin dependent diabetes mellitus						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicida		26a. Date of Injury (Month, Day Year)		26b. Time of Injury M		26c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		26d. Describe how injury occurred
		26a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		26f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier [Signature]				29c. License number D19431		29d. Date signed (Month, Day, Year) 7/17/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Funeral Records, 11701 Livingston Rd #203 Ft. Washington MD 20744								
31. Date filed (Month, Day, Year) JUL 19 1996				32. Registrar's Signature John A. Randall				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23104

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM NOEL FLIPPO, JR.

2. Date of Death

Month Day Year
JULY 15, 1996

3. Time of Death

4.20 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Prince Georges Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince Georges

5. Social Security Number

578-34-1302

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

October 31, 1927

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland Prince Georges

10b. County

10c. City, Town or Location

Colmar Manor

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3600 42nd Avenue

10f. Zip Code

20722

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Drug Store

17. Father's Name (First, Middle, Last)

William Flippo, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Helen Margaret Hopan

19a. Informant's Name/Relationship (Type, Print)

Margaret A. Flippo - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3600 42nd Avenue, Colmar Manor, Maryland 20722

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Crematory

Date

July 17, 1996

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fort Lincoln Funeral Home, Inc.
3401 Bladensburg Rd., Brentwood, Maryland 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Diabetic Mellitus

Due to (or as a consequence of):

d. Hypertension

Approximate Interval Between Onset and Death

24 hours

20 years

20 years

20 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LEFT CAROTID ENDARTERECTOMY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D23586

29d. Date signed (Month, Day, Year)

7/11/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

BRIAN S. BAYLY, MD, 7223 Hanover Parkway #B Greenbelt, Maryland 20770

31. Date filed (Month, Day, Year)

JUL 17 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23105

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MONDEL		2. Date of Death Month JULY Day 05 Year 1996		3. Time of Death 2032PM
	4e. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER E.R.		4b. City, Town, or Location of Death CHEVERLY		4c. County of Death PRINCE GEORGES
Funeral Director	5. Social Security Number 218-88-8426	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 20 Yrs.	8. Date of Birth (Month, Day, Year) Oct. 17, 1975	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10e. State MD.	10b. County Prince Georges	10c. City, Town or Location Palmer Park		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 7609 Normandy Road		10f. Zip Code 20785		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Furniture Assembler		16b. Kind of Business/Industry Private Industry
	17. Father's Name (First, Middle, Last) Raymond Ford		18. Mother's Name (First, Middle, Maiden Surname) Olivia Epps		
	19e. Informant's Name/Relationship (Type, Print) Olivia Ford (Mother)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7609 Normandy Rd., Palmer Park, Md. 20785		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Cemetery		20c. Location - City or Town, State July 13, 1996 Landover, MD.
	21. Signature of Funeral Service Licensee <i>Ralph Williams</i>		22. Name and Address of Facility Ralph Williams Funeral Service 517 11th Street, S.E.; Wash., DC		
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gunshot wound of chest Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24e. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined					
28e. Date of Injury (Month, Day, Year) 7-5-96					
28b. Time of Injury 1946 hrs					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred Subject shot					
28f. Location (Street and Number or Rural Route Number, City or Town, State) 7609 Normandy Road Landover, Prince Georges, MD					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Donald G. Wright MD</i>					
29c. License number O.C.M.E.					
29d. Date signed (Month, Day, Year) JULY 06, 1996					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) JUL 17 1996					
32. Registrar's Signature <i>John Davidson-Russell</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

4

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 23106

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILHEMINA FORD				2. DATE OF DEATH MONTH JULY DAY 5 YEAR 1996		3. TIME OF DEATH 8:30 PM	
4. SOCIAL SECURITY NUMBER 245 16 8301		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) JULY 27, 1919	
8. BIRTHPLACE (State or Foreign Country) HENDERSON, NC				9a. FACILITY NAME (If not institution, give street and number) FIRNWOOD HOUSE 6530 DEMOCRACY BLVD.		9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA	
9c. COUNTY OF DEATH MONTGOMERY				10a. STATE MARYLAND		10b. COUNTY PRINCE GEORGE'S	
10c. CITY, TOWN OR LOCATION CAPITAL HEIGHTS				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 22 MARYLAND PARK DR.	
10f. ZIP CODE 20743				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: BLACK				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) COSMETOLOGIST				16b. KIND OF BUSINESS/INDUSTRY PRIVATE INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) CHARLIE WHITESIDE				18. MOTHER'S NAME (First, Middle, Maiden Surname) PEARL HAMILTON WHITESIDE			
19a. INFORMANT'S NAME (Type/Print) SPENCER MORRIS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1623 G ST SE WASHINGTON, DC 20020			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MARYLAND NATIONAL			
20c. LOCATION — City or Town, State 7/12/96 LAUREL, MD				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Chifton Layne</i>			
22. NAME AND ADDRESS OF FACILITY ROBERT G. MASON FUNERAL HOME 1661 GOOD HOPE RD. SE WASHINGTON, DC 20020				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Lung Tumor IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death months			
24. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's Disease				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 7/12/96			
28b. TIME OF INJURY M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) At home				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 940 Old Georgetown rd. Bethesda MD 20815				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Schulman</i>				29c. LICENSE NUMBER 020516			
29d. DATE SIGNED (Month, Day, Year) 7/12/96				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Schulman 940 Old Georgetown rd. Bethesda MD 20815			
31. DATE FILED (Month, Day, Year) JUL 18 1996				32. REGISTRAR'S SIGNATURE <i>John Schulman</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #18, P.B. & C. 7/18/96

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23107

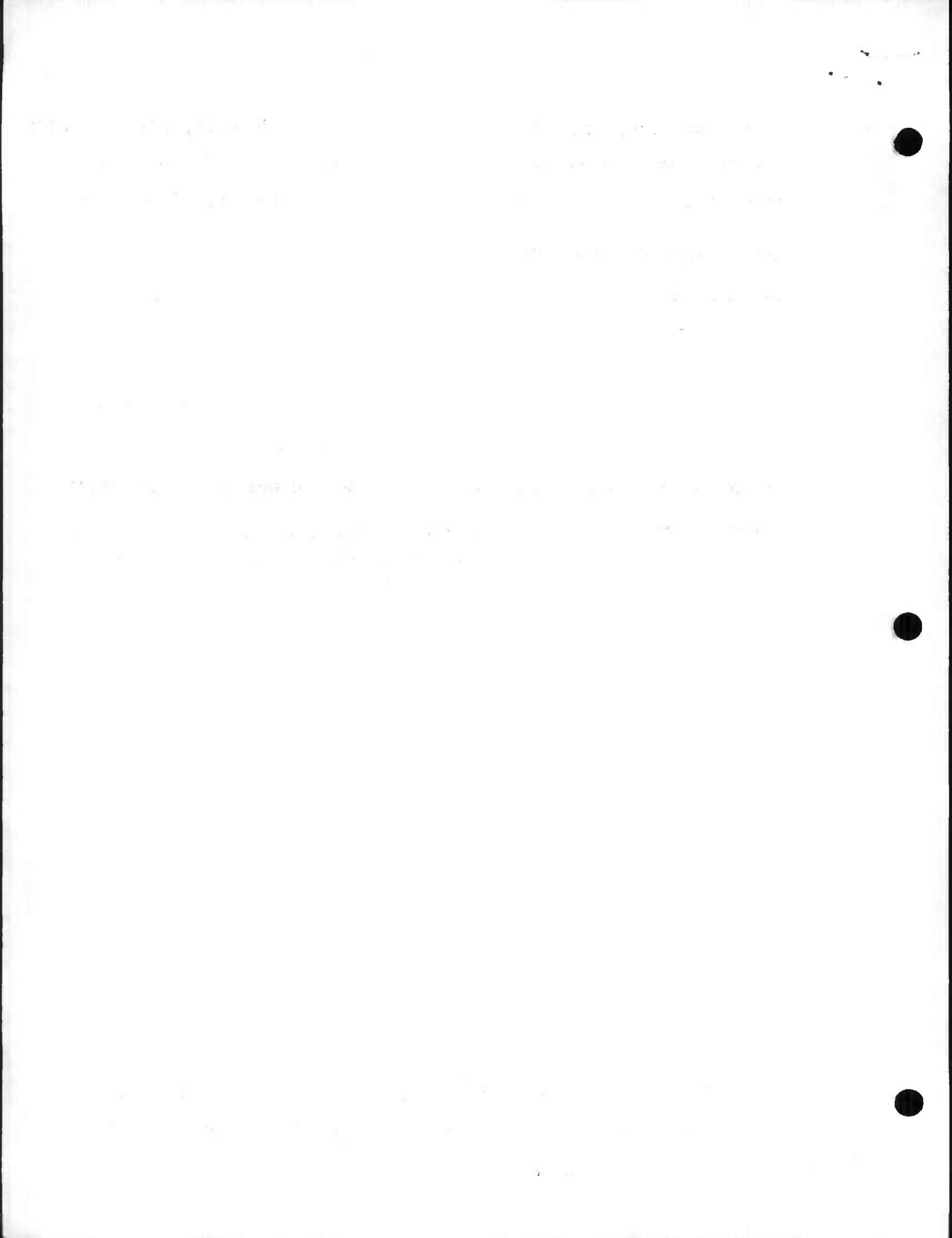
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Glenna Grace FINCHAM</i>				2. Date of Death Month <i>July</i> Day <i>10</i> Year <i>1996</i>		3. Time of Death <i>10:03 PM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Doctors' Community Hospital</i>				4b. City, Town, or Location of Death <i>Lanham</i>		4c. County of Death <i>Prince George's</i>	
Funeral Director	5. Social Security Number <i>491-30-1412</i>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>68</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Sept. 10, 1927</i>	
	Usual Residence of Decedent 10a. State <i>Maryland</i> 10b. County <i>Prince George's</i> 10c. City, Town or Location <i>Greenbelt</i>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <i>2A Laurel Hill Road</i>		10f. Zip Code <i>20770</i>	
To Be Completed by Funeral Director	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Clerk Typist</i>		16b. Kind of Business/Industry <i>Federal Government</i>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <i>John Beal</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Grace Marie Hyatt Hoyt</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Herbert Lee Fincham / Husband</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2A Laurel Hill Road, Greenbelt, Maryland 20770</i>			
Physician /Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>George Washington Cem. 7/15/1996</i>		20c. Location - City or Town, State <i>Adelphi, Maryland</i>		20d. Date <i>7/15/1996</i>	
	21. Signature of Funeral Service Licensee <i>Coni Lynn Gersch-Hardy</i>		22. Name and Address of Facility <i>Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781</i>					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Septic</i>						Approximate Interval Between Onset and Death <i>6 days</i>	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Renal Failure, Congestive Heart Failure, Diabetes Mellitus</i>						23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <i>7/15/1996</i>		28b. Time of Injury <i>M</i>	
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State) <i>115 Centerway Greenbelt, MD 20770</i>			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>David Granite, MD</i>		29c. License number <i>D17572</i>		29d. Date signed (Month, Day, Year) <i>7/16/1996</i>	
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>David Granite MD 115 Centerway Greenbelt, MD 20770</i>							
	31. Date filed (Month, Day, Year) <i>JUL 16 1996</i>				32. Registrar's Signature <i>Juanita Marshall</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



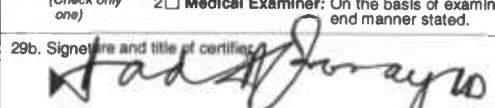
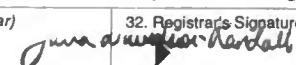
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23108

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Henry Fisher						2. Date of Death Month July Day 11 Year 1996		3. Time of Death 5:15 AM																														
	4e. Facility Name (If not institution, give street and number) Prince George's Hospital						4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's																														
Funeral Director	5. Social Security Number 068-14-0348		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) July 29, 1917		9. Birthplace (State or Foreign Country) North Carolina																														
	Usual Residence of Decedent																																						
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Capital Heights				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																														
	10e. Street and Number 1446 Karen Boulevard				10f. Zip Code 20743		10g. Citizen of What Country? USA																																
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 4-6/41 8-25-42		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black																															
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Statistical Clerk			16b. Kind of Business/Industry Government																															
	17. Father's Name (First, Middle, Last) William A. Fisher						18. Mother's Name (First, Middle, Maiden Surname) Carrie Collins																																
	19a. Informant's Name/Relationship (Type, Print) Janice Fisher/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1446 Karen Boulevard, Capital Heights MD 20743																																		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland National Cem.		Date 7/15/96		20c. Location - City or Town, State Laurel, Maryland																																
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road, Landover MD 20785																																		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																						
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Acute Myocardial Infarction</td> <td>10 days</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td>Severe Ischemic Cardiomyopathy</td> <td>5 years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td rowspan="3">Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td>Diffuse Arteriosclerosis</td> <td>10 years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a.	Acute Myocardial Infarction	10 days	Due to (or as a consequence of):			b.	Severe Ischemic Cardiomyopathy	5 years	Due to (or as a consequence of):			Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	Diffuse Arteriosclerosis	10 years	Due to (or as a consequence of):			d.								
Immediate Cause (Final disease or condition resulting in death)	a.	Acute Myocardial Infarction	10 days																																				
	Due to (or as a consequence of):																																						
	b.	Severe Ischemic Cardiomyopathy	5 years																																				
	Due to (or as a consequence of):																																						
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	Due to (or as a consequence of):																																						
	d.																																						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																																							
<table border="1"> <tr> <td colspan="6">Congestive Heart Failure</td> <td colspan="4">23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="6">Diabetes Mellitus</td> <td colspan="4">24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> <tr> <td colspan="6">Carotid Artery Disease</td> <td colspan="4">24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> </table>										Congestive Heart Failure						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				Diabetes Mellitus						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				Carotid Artery Disease						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
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25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																							
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																																							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined																																							
28a. Date of Injury (Month, Day Year) 7-15-96																																							
28b. Time of Injury M																																							
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																							
28d. Describe how injury occurred																																							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																																							
28f. Location (Street and Number or Rural Route Number, City or Town, State)																																							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																																							
29b. Signature and title of certifier 																																							
29c. License number 528195																																							
29d. Date signed (Month, Day, Year) 7-11-96																																							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID A. GODRAY, MD. 12164 CONTRAL AVE. MITCHELLVILLE MD 20721																																							
31. Date filed (Month, Day, Year) JUL 15 1996																																							
32. Registrar's Signature 																																							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23109

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LILA M. Gordon				2. Date of Death Month July Day 16 Year 1996		3. Time of Death 330 AM
	4a. Facility Name (If not institution, give street and number) SUBURBAN HOSPITAL				4b. City, Town, or Location of Death BETHESDA		4c. County of Death MONTGOMERY
Funeral Director	5. Social Security Number 162-22-2205	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 4/1/28	9. Birthplace (State or Foreign Country) CHESTER, SC
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State MD	10b. County MONTGOMERY	10c. City, Town or Location SILVER SPRING			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 1656 NORDIC HILL CIRCLE			10f. Zip Code 20906		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YEARS College (1-4 or 5+) 5+ YEARS		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SCHOOL TEACHER		16b. Kind of Business/Industry EDUCATION		
	17. Father's Name (First, Middle, Last) ROBERT MOORE			18. Mother's Name (First, Middle, Maiden Summa) AMANDA BROWN			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) CLARENCE R. GORDON			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS 10A, B, C, D, E, & F			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY		Date 7/27/96	20c. Location - City or Town, State ALEXANDRIA, VA.	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility JOHN T. RHINES CO., INC. 3030 12TH ST NE, DC 20017			
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SEPSIS Due to (or as a consequence of): BACTERIAL PNEUMONIA Due to (or as a consequence of): CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): HYPERTENSION						Approximate Interval Between Onset and Death 12 HOURS 5 DAYS 12 DAYS MANY YEARS
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. INTESTINAL ILEUS DIABETES MELLITUS ATRIAL FIBRILLATION						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier HAMMETT MD		29c. License number D39966		29d. Date signed (Month, Day, Year) 7/16/96	
30. Name and address of person who completed causa of death (Item 23e) (Type, Print) CAROLYN HAMMETT, MD., 6111 EXECUTIVE BLVD., ROCKVILLE, MD., 20852							
31. Date filed (Month, Day, Year) JUL 19 1996				32. Registrar's Signature 			

.M

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23110

Amended # 8 P.G.C 7-24-96 CR

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PATRICIA M. GILLIAM

2. Date of Death

Month

Day

Year

July

10, 1996

3. Time of Death

9:30 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

578-52-1425

6. Sex

1 ☐ M2 ☒ F

7. Age (In yrs. last birthday)

57

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

July 16, 1996

9. Birthplace

(State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7518 Eastern Avenue

10f. Zip Code

20012

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

Charles A. Gussom

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Anderson

19a. Informant's Name/Relationship (Type, Print)

Robert A. Gilliam, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7518 Eastern Avenue, Washington, D.C. 20012

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Fort Lincoln Cemetery

Data

20c. Location - City or Town, State

7-15-96 Brentwood, Maryland

21. Signature of Funeral Service Licensee

Lisa S. Johnson

22. Name and Address of Facility

Fort Lincoln Funeral Home, Inc.

3401 Bladensburg Rd., Brentwood, Maryland 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Approximate

Interval Between

Onset and Death

Immediate Cause (Final

disease or condition

resulting in death)

a.

Congenitive Heart Failure

Due to (or as a consequence of):

3-6 months

b.

Myocardial Dysfunction and Renal failure

Due to (or as a consequence of):

7 years

c.

Coronary Artery Disease

Due to (or as a consequence of):

10 yrs.

d.

Diabetes, Atherosclerotic Heart Disease

Due to (or as a consequence of):

20 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury et

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28b. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

29b. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Signature and title of certifier

Pradeep Srivastava, MD

29e. License number

D 33483

29f. Date signed (Month, Day, Year)

7/12/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRADEEP SRIVASTAVA, MD, 7227-B Hanover Parkway, Gaithersburg, MD 20878

31. Date filed (Month, Day, Year)

JUL 17 1996

32. Registrar's Signature

Julia Davidson-Rodwell

State
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23111

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Agnes R. Goff				2. Date of Death Month Day Year July 12, 1996				3. Time of Death 0300						
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital				4b. City, Town, or Location of Death Prince Frederick				4c. County of Death Calvert						
Funeral Director	5. Social Security Number 577-10-5508		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 11, 1913		9. Birthplace (State or Foreign Country) Maryland						
	Usual Residence of Decedent 10a. State Maryland 10b. County Calvert 10c. City, Town or Location Lusby 10d. Inside City Limits <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 11523 Ropeknot Road		10f. Zip Code 20657		10g. Citizen of What Country? U.S.A.						
To Be Completed by Funeral Director	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home								
	17. Father's Name (First, Middle, Last) John C. Doyle				18. Mother's Name (First, Middle, Maiden Summa) Mary Valandingham										
	19e. Informant's Name/Relationship (Type, Print) Asa A. Goff - Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11523 Ropeknot Rd. Lusby, Maryland 20657										
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		Date 7/16/96		20c. Location - City or Town, State Clinton, Maryland								
	21. Signature of Funeral Service Licensee <i>George P. Kalas</i>		22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>Coronary Artery Disease</u> Due to (or as a consequence of): b. <u>Atherosclerosis</u> Due to (or as a consequence of): c. <u>Diabetes</u> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death 8 days years years								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CHF - congestive heart failure</u>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Michael Dugas</i>				29c. License number D38991		29d. Date signed (Month, Day, Year) July 12, 1996							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL DUGAS 1201 NORTON ROAD PRINCE FREDERICK MD 20678				31. Date filed (Month, Day, Year) JUL 15 1996				32. Registrar's Signature <i>John A. ...</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. The first part of the report

describes the general situation

and the results of the survey

2. The second part of the report

describes the detailed results

of the survey

3. The third part of the report

describes the conclusions

4. The fourth part of the report

describes the recommendations

for the future

5. The fifth part of the report

describes the appendix

6. The sixth part of the report

describes the bibliography

7. The seventh part of the report

describes the index

8. The eighth part of the report

describes the list of figures

9. The ninth part of the report

describes the list of tables

10. The tenth part of the report

describes the list of references

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23112

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>CHARLES GRIFFITH</u> Charles Chesleigh Griffith, Jr.				2. Date of Death Month Day Year 9 96		3. Time of Death 7:50 a.m.		
	4a. Facility Name (If not institution, give street and number) <u>UNIVERSITY OF MARYLAND HOSPITAL</u>				4b. City, Town, or Location of Death <u>BALTIMORE</u>		4c. County of Death		
Funeral Director	5. Social Security Number <u>155-05-2771</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>74</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>Feb 18, 1922</u>		
	9. Birthplace (State or Foreign Country) <u>Delaware</u>								
Usual Residence of Decedent									
10a. State <u>Maryland</u>		10b. County <u>Dorchester</u>		10c. City, Town or Location <u>Cambridge</u>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <u>705 Twin Point Cove Road</u>				10f. Zip Code <u>21613</u>		10g. Citizen of What Country? <u>US</u>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <u>WW II</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>5+</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Physical Education Teacher</u>			16b. Kind of Business/Industry <u>Education</u>		
17. Father's Name (First, Middle, Last) <u>Charles Chesleigh Griffith, Sr.</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Miriam Moore</u>					
19a. Informant's Name/Relationship (Type, Print) <u>Stephen D. Griffith Son</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>705 Twin Point Cove Road Cambridge, Maryland 21613</u>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Green Lawn Cemetery</u>		Date <u>7/12/96</u>		20c. Location - City or Town, State <u>Cambridge, Maryland</u>			
21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613</u>					
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. <u>pneumonia</u> Due to (or as a consequence of): b. <u>cardiac arrhythmia</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>renal failure</u> <u>atrial fibrillation</u>									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>R8485</u>		29d. Date signed (Month, Day, Year) <u>7/9/96</u>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <u>JEANETTE NAZARIAN, MD 22 S. GREENE ST., BALTIMORE, MD</u>									
31. Date filed (Month, Day, Year) <u>JUL 26 1996</u>		32. Registrar's Signature <u>[Signature]</u>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23113

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EMMA SAMPLES HOLMES				2. Date of Death Month Day Year JULY 13, 1996		3. Time of Death 6:26PM	
	4a. Facility Name (If not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL				4b. City, Town, or Location of Death TAKOMA PARK		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 578-30-7138		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 6, 1909	
	9. Birthplace (State or Foreign Country) GEORGIA		10a. State MARYLAND		10b. County PRINCE GEORGE'S		10c. City, Town or Location UPPER MARLBORO	
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 303 PRAIRIE COURT		10f. Zip Code 20774		
10g. Citizen of What Country? USA		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SEAMSTRESS		16b. Kind of Business/Industry PRIVATE		
17. Father's Name (First, Middle, Last) PRINCE ALBERT BUSBY		18. Mother's Name (First, Middle, Maiden Surname) SARAH GARVIN		19a. Informant's Name/Relationship (Type, Print) MABLE MOSLEY EVANS/ NIECE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 PRAIRIE COURT UPPER MARLBORO, MARYLAND 20774		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HARMONY MEMORIAL PARK		20c. Date 7-19-96		20d. Location - City or Town, State LANDOVER, MARYLAND		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility MARSHALL'S FUNERAL HOME 4308 SUITLAND RD. SUITLAND, MD 20746		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. CARDIOPULMONARY ARREST Due to (or as a consequence of): PNEUMONIA RESPIRATORY FAILURE Due to (or as a consequence of): RENAL FAILURE		Approximate Interval Between Onset and Death SUDDEN SUDDEN DAYS MONTHS		
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION ANEMIA		23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 7/19/96		
28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D32332		
29d. Date signed (Month, Day, Year) 7/19/96		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SK GUPTA, MD 9801 GEORGIA AVE #220 SILVER SPRING, MD 20902		31. Date filed (Month, Day, Year) JUL 15 1996		32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural," or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23114

Certificate of Death

Reg. No.

3 1/2

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

(3)

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) VERNARD LEE HILL		2. Date of Death Month JULY Day 15 Year 1996		3. Time of Death 3:50 PM	
4a. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER			4b. City, Town, or Location of Death CHEVERLY		4c. County of Death PRINCE GEORGES
5. Social Security Number 578-84-0040		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 39 Yrs.	
8. Date of Birth (Month, Day, Year) Feb 5, 1957		9. Birthplace (State or Foreign Country) Sussex Co., VA			
10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location Landover, Maryland	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 7710 Willow Hill Drive		10f. Zip Code 20785	
10g. Citizen of What Country? United States		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) Collage (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Private	
17. Father's Name (First, Middle, Last) Willie Hill		18. Mother's Name (First, Middle, Maiden Surname) Sarah Adkins			
19a. Informant's Name/Relationship (Type, Print) Robert Hill/Brother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7710 Willow Hill Drive Landover, MD 20785			
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glenwood Cemetery		20c. Location - City or Town, State Washington, D.C.	
21. Signature of Funeral Service Licensee <i>Alex S. Pope Jr.</i>		22. Name and Address of Facility Alexander S. Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 20747			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Peritonitis Due to (or as a consequence of): b. Perforated Stomach ulcer Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>Dennis J. Chute</i>		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 16, 1996	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) JUL 19 1996		32. Registrar's Signature <i>Julia Anderson-Randall</i>			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23115

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROSE

2. Date of Death

Month Day Year
July 15, 1996

3. Time of Death

11:25AM

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

577-44-7322

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
03-03-33

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Landover

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2718 Kelner Drive

10f. Zip Code

20785

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Yancey Swindall

18. Mother's Name (First, Middle, Maiden Surname)

Lennie Hill

19a. Informant's Name/Relationship (Type, Print)

Leonard Heard/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2718 Kelner Drive, Landover MD 20785

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Maryland National Cem.

Date

7/20/96

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perentis

22. Name and Address of Facility

J. B. Jenkins Funeral Home

7474 Landover Road, Landover MD 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Septic Syndrome with Acute Renal

Approximate
Interval Between
Onset and Death

1 week

Due to (or as a consequence of):

Failure

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Metastatic Brain tumor

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

28. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

Wendy V. covering for attending

29c. License number

D20077

29d. Date signed (Month, Day, Year)

7/16/96

30. Name and address of person who completed cause of death (item 23e) (Type, Print)

DON W. YADLOVITZ, MD 7404 EXECUTIVE PL. # 502, NEWBROOK, MD 20704

31. Date filed (Month, Day, Year)

JUL 18 1996

State
Registrar

Baltimore, Maryland 21215-0020

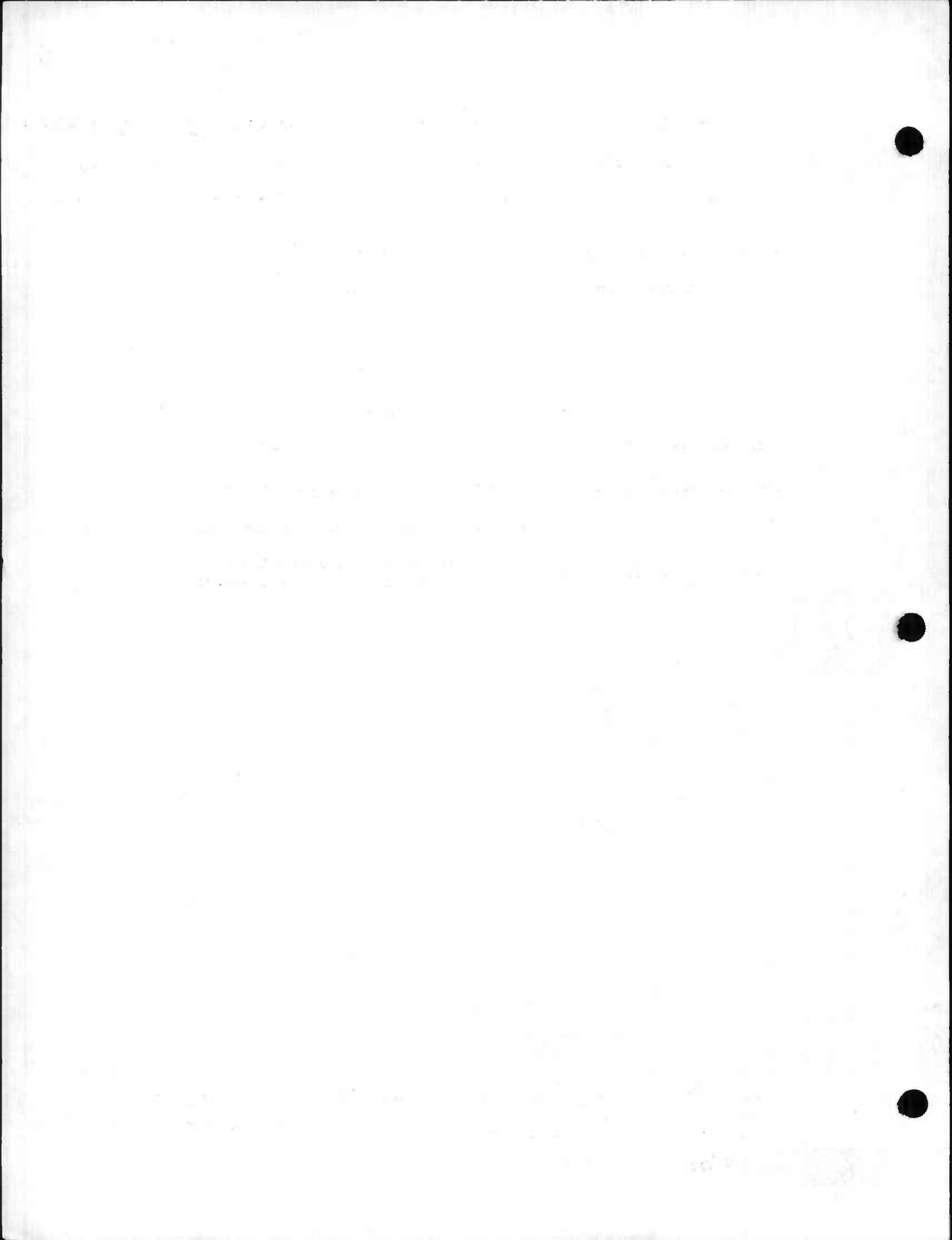
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23116

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Roger Isaac				2. Date of Death Month July Day 16 Year 1996		3. Time of Death 9:00 AM	
	4a. Facility Name (If not Institution, give street and number) Howard County General Hospital				4b. City, Town, or Location of Death Columbia		4c. County of Death Howard County	
Funeral Director	5. Social Security Number 248-30-4791		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 72 Yrs.	# Under 1 Year Months Days	# Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 1923 September 23,	9. Birthplace (State or Foreign Country) Springfield, South Carolina
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Mitchelville			10d. Inside City Limits 1 Yes 2 No		
	10e. Street and Number 10162 Manor Lake Terrace			10f. Zip Code 20721		10g. Citizen of What Country? United States of America		
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+)		18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Railroad Repairman			16b. Kind of Business/Industry Railroad		
	17. Father's Name (First, Middle, Last) John Issac				18. Mother's Name (First, Middle, Maiden Surname) Jessie Prophet			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Roger Issac, Jr. /Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1016 Manor Lake Terrace, Mitchelville, MD 20721			
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Pleasant Branch Church Cemetery		Date 7/20/96	20c. Location - City or Town, State Norway, South Carolina		
	21. Signature of Funeral Service Licensee Howard A. Carson #M00690		22. Name and Address of Facility Newton Funeral Home 204 Amelia Street, Orangeburg, SC 29115					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Sepsis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 2 weeks
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
25. Was case referred to medical examiner? 1 Yes 2 No							28. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify)	
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier William Flowers MD		29c. License number D20789		29d. Date signed (Month, Day, Year) July 16, 1996		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) William Flowers MD 11055 Little Patuxent Columbia Md.								
31. Date filed (Month, Day, Year) JUL 19 1996		32. Registrar's Signature John Davidson-Randall						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23117

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BERTHA H JOHNSON				2. Date of Death Month Day Year July 16, 1996		3. Time of Death 7:30 A.M.	
	4a. Facility Name (If not institution, give street and number) 18301 Indian Head Hwy.				4b. City, Town, or Location of Death Accokeek		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 577-12-6068	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 25, 1902		9. Birthplace (State or Foreign Country) Washington, D.C.
	Usual Residence of Decedent							
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Accokeek		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 18505 Indian Head Hwy				10f. Zip Code 20607		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk		16b. Kind of Business/Industry Government		
17. Father's Name (First, Middle, Last) Unknown				18. Mother's Name (First, Middle, Maiden Surname) Dililah Hill				
19a. Informant's Name/Relationship (Type, Print) Herbert Johnson - Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 87, Bryans Road, Maryland 20616				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Memorial Cemetery		20c. Date 7/19/96		20d. Location - City or Town, State Suitland, Maryland		
21. Signature of Funeral Service Licensee <i>John T. Stewart III</i>				22. Name and Address of Facility STEWART FUNERAL HOME, Inc. 4001 Benning Road, N.E., Washington, D. C.				
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death) Respiratory failure Chronic								
Due to (or as a consequence of): Coronary artery disease								
Due to (or as a consequence of): Chronic pulmonary disease								
Due to (or as a consequence of):								
Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. severe degenerative of spine								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Group Home						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						
28e. Location (Street and Number or Rural Route Number, City or Town, State)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number 09285		29d. Date signed (Month, Day, Year) July 16, 1996		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Habib Farhoudi, M.D. 6196 Oxon Hill Rd, Suite 200 Oxon Hill, MD 20745								
31. Date filed (Month, Day, Year) JUL 19 1996				32. Registrar's Signature <i>John Davidson-Randall</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

6

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23118

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY LOU JEFFERIS

2. Date of Death

Month
JULY

Day

06

Year

1996

3. Time of Death

1040 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

JONES POINT POTOMAC RIVER

4b. City, Town, or Location of Death

4c. County of Death

PRINCE GEORGES

5. Social Security Number

577-74-7719

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

40

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

Aiken, SC

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Oxon Hill

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

708 Audrey Lane

10f. Zip Code

20745

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African-American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

not employed

16b. Kind of Business/Industry

NA

17. Father's Name (First, Middle, Last)

Charles Jefferis Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Lille Mae Rush

19a. Informant's Name/Relationship (Type, Print)

Lillie Mae Jefferis / Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

708 Audrey Lane, Oxon Hill, MD 20745

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

7-11-96

20c. Location - City or Town, State

Landover, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Strickland Funeral Service

507 Silver Fox Turn, Clinton, MD 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Drowning
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. _____
Due to (or as a consequence of):c. _____
Due to (or as a consequence of):d. _____
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☒ Other (Specify)

RIVER

27. Manner of Death

☐ Natural☐ Accident☒ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined☐ Could not be determined☐ Could not be determined

28a. Date of Injury (Month, Day Year)

7/6/96

28b. Time of Injury

0415 HA

28c. Injury at Work?

☐ Yes ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Potomac River

28d. Describe how Injury occurred Subject jumped off bridge and drowned in river

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Woodrow Wilson Bridge over Potomac River

29a. Certifier (Check only one)

☐ Certifying Physician☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

JULY 7, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Theodor M. King

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 18 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23119

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kenneth Doswell Jackson, Sr.				2. Date of Death Month Day Year July 13, 1996		3. Time of Death 12:10 A.M.		
	4e. Facility Name (If not institution, give street and number) 317 N. Summit Drive, Apt. 3A				4b. City, Town, or Location of Death Gaithersburg		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 578-38-0193		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 25, 1929	9. Birthplace (State or Foreign Country) Washington, D.C.	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Gaithersburg			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 317 N. Summit Drive, Apt. 3A				10f. Zip Code 20877		10g. Citizen of What Country? United States		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retired Police Officer		16b. Kind of Business/Industry Government				
	17. Father's Name (First, Middle, Last) Francis Jackson				18. Mother's Name (First, Middle, Maiden Surname) Elsie Harrod				
	19a. Informant's Name/Relationship (Type, Print) Betty Jackson - Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 317 N. Summit Drive, Apt 3A, Gaithersburg, MD 20877				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery 7/18/96 Cheltenham, MD		Date		20c. Location - City or Town, State		
	21. Signature of Funeral Service Licensee John T. Stewart III		22. Name and Address of Facility STEWART FUNERAL HOME, Inc. 4001 Benning Road, N.E., Washington, D. C.						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. Lung Cancer Due to (or as a consequence of): f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death One Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier John T. Stewart III		29c. License number D33686		29d. Date signed (Month, Day, Year) July 15, 1996				
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Kenneth M. Miller, MD 18111 Prince Philip Pl. Olney, MD 20852								
	31. Date filed (Month, Day, Year) JUL 16 1996		32. Registrar's Signature John T. Stewart III						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23120

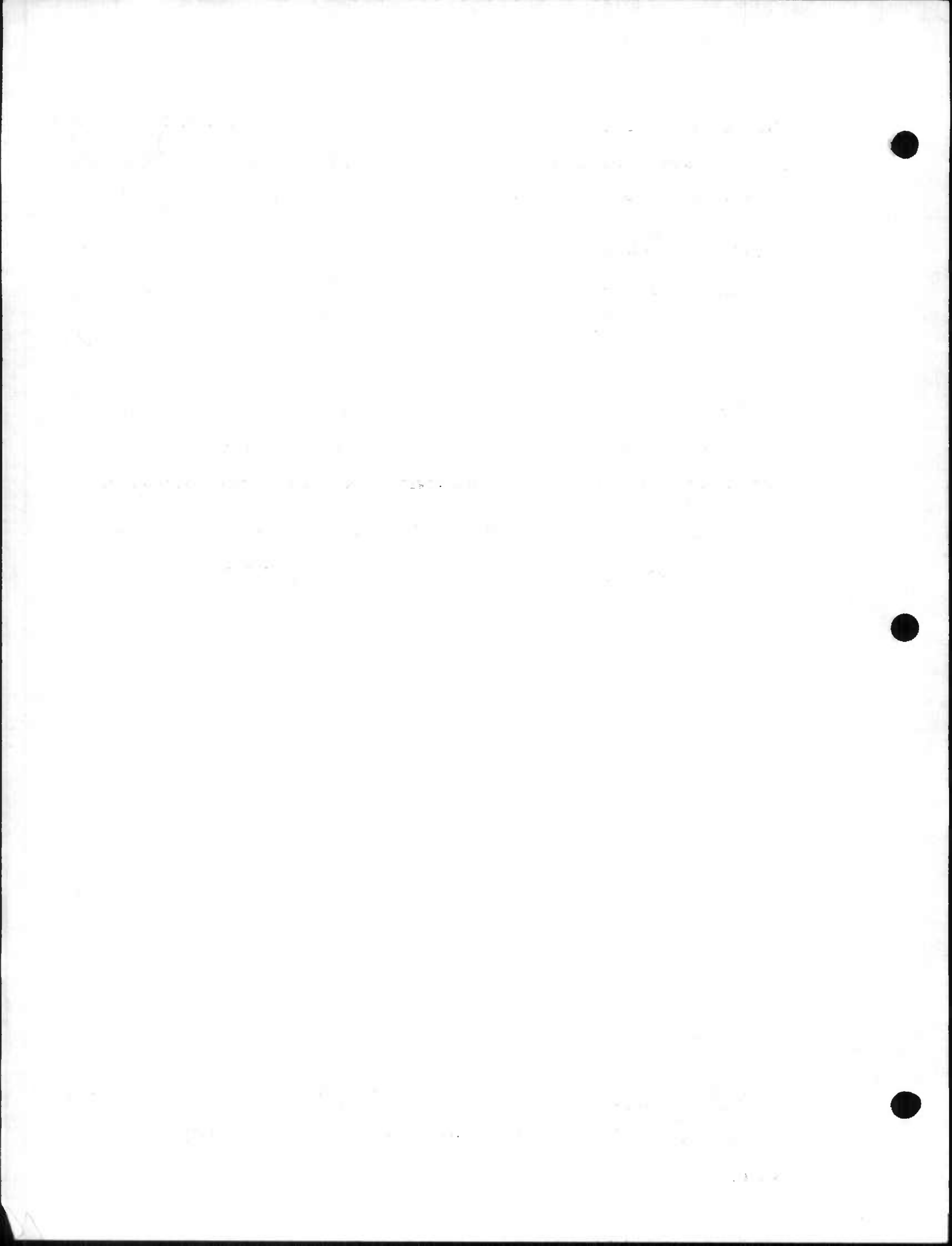
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM E JOHNSON				2. Date of Death Month Day Year JULY 10, 1996		3. Time of Death 12:25 P													
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death													
Funeral Director	5. Social Security Number 216-60-9875		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 42 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 08 05 53	9. Birthplace (State or Foreign Country) Maryland												
	Usual Residence of Decedent																			
To Be Completed by Funeral Director	10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Severn		10d. Inside City Limits Yes 2 No													
	10e. Street and Number 7936 Tower Court Road				10f. Zip Code 21144		10g. Citizen of What Country? USA													
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 7/5/72 6/30/78		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black													
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician		16b. Kind of Business/Industry Government															
	17. Father's Name (First, Middle, Last) William Edward Johnson Sr.				18. Mother's Name (First, Middle, Maiden Surname) Idella Parker															
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Patricia Johnson/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7936 Tower Court Road, Severn, Maryland 21144															
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veteran's		Date 7/16/96		20c. Location - City or Town, State Cheltenham, Maryland													
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road, Landover MD 20785															
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Brain death</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b. Infectious vasculitis</td> <td>Due to (or as a consequence of):</td> <td>2 days</td> </tr> <tr> <td>c. Basal meningitis of unknown cause</td> <td>Due to (or as a consequence of):</td> <td>2 months</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Brain death	Due to (or as a consequence of):		b. Infectious vasculitis	Due to (or as a consequence of):	2 days	c. Basal meningitis of unknown cause	Due to (or as a consequence of):	2 months	d.	
Immediate Cause (Final disease or condition resulting in death)	a. Brain death	Due to (or as a consequence of):																		
	b. Infectious vasculitis	Due to (or as a consequence of):	2 days																	
	c. Basal meningitis of unknown cause	Due to (or as a consequence of):	2 months																	
	d.																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown														
						24a. Was an autopsy performed? Yes 2 <input type="checkbox"/> No														
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)																		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred												
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)														
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Dr. Williams MD																		
		29c. License number D40041		29d. Date signed (Month, Day, Year) July 10, 1996																
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Michael A Williams 600 N. Wolfe Street, Nether 8-150																				
31. Date filed (Month, Day, Year) JUL 15 1996		32. Registrar's Signature Julia Dravon-Randall																		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23121

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Leonard Milton Kerby				2. Date of Death Month Jul Day 13 Year 1996		3. Time of Death 1259PM	
	4a. Facility Name (If not institution, give street and number) 133 Konrad Morgan Way				4b. City, Town, or Location of Death Lothian		4c. County of Death AA	
Funeral Director	5. Social Security Number 579-24-2139		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) 6-30-26	
	9. Birthplace (State or Foreign Country) Washington, D.C.		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Lothian	
To Be Completed by Funeral Director	10e. Street and Number 133 Konrad Morgan Way				10f. Zip Code 20711		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10TH College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Water Department Engineer		16b. Kind of Business/Industry Federal Government	
	17. Father's Name (First, Middle, Last) Leonard R. Kerby				18. Mother's Name (First, Middle, Maiden Surname) Nettie Prescott			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Myrtle R.A. Kerby/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 133 Konrad Morgan Way Lothian, Md. 20711			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State 7-16 Alexandria, Virginia		21. Signature of Funeral Service Licensee George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745	
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Gun Shot Wound, Chest Due to (or as a consequence of):						Approximate Interval Between Onset and Death UNK	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 7/13/96		28b. Time of Injury UNK M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred Subject Shot Self.						28f. Location (Street and Number or Rural Route Number, City or Town, State) Lothian, MD.	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier Deputy William P. Jones, MD	
To Be Completed by Physician/Medical Examiner	29c. License number D06054						29d. Date signed (Month, Day, Year) 7/13/96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William P. Jones, MD 695 America 21035							
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) JUL 17 1996						32. Registrar's Signature John Davidson-Randall	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transportation certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23122

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LEROY KING, Jr.

2. Date of Death

Month Day Year
JULY 13, 1996

3. Time of Death

4:40pm

4a. Facility Name (If not institution, give street and number)

DOCTORS COMMUNITY HOSPITAL

4b. City, Town, or Location of Death

LANHAM

4c. County of Death

PRINCE GEORGE'S CO

Funeral
Director

5. Social Security Number

579-56-7406

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

51

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Feb. 23, 1945

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10e. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

College Park

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5962 West Chester Park Drive, #301

10f. Zip Code

20740

10g. Citizen of What Country?

United States

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
African American

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)Retired
Asst. to Director of Security

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Leroy King, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Celeste Wharton

19e. Informant's Name/Relationship (Type, Print)

Marie Morris - Aunt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

615 11th Street, N.E., Washington, D.C. 20002

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Harmony Memorial Park

Date

7/20/96

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

STEWART FUNERAL HOME, Inc.

4001 Benning Road, N. E., Washington, D. C.

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Respiratory failure
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

4 days

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Brain death
Due to (or as a consequence of):c. Acute large intracerebral infarct-
Due to (or as a consequence of):

d. Pneumonia Right lung.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Renal insufficiency

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural
☐ Accident
☐ Suicide
☐ Homicide
☐ Pending investigation
☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Bredapin

29c. License number

D 24174

29d. Date signed (Month, Day, Year)

7/15/1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PADMAJA S. UDAPSI 7245 HANOVER OFFICE PARK SUITE B GREENBELT
20770State
Registrar

31. Date filed (Month, Day, Year)

JUL 19 1996

32. Registrar's Signature

John Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23123

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ethel Alice Kauffman				2. Date of Death Month Day Year July 13, 1996		3. Time of Death 3:00 am	
	4a. Facility Name (If not institution, give street and number) 3912 Madison Street				4b. City, Town, or Location of Death Hyattsville		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 577-20-7034		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 101 Yrs.		8. Date of Birth (Month, Day, Year) March 31, 1895	
	9. Birthplace (State or Foreign Country) Nebraska		10a. State MD		10b. County Prince George's		10c. City, Town or Location Hyattsville	
To Be Completed by Funeral Director	10d. Inmate City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 3912 Madison Street		10f. Zip Code 20781		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 Collage (1-4 or 5+) 		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Adjustment Clerk		16b. Kind of Business/Industry Kann's			
	17. Father's Name (First, Middle, Last) Franklin B. Cope				18. Mother's Name (First, Middle, Maiden Surname) Sarah A. Matter			
	19a. Informant's Name/Relationship (Type, Print) Dwayne E. Kauffman / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19434 Murphy Lane, Ruther Glen, Virginia 22546			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 7/16/1996		20c. Location - City or Town, State Brentwood, Maryland			
	21. Signature of Funeral Service Licensee Francis Gasch's Sons Funeral Home, P.A.		22. Name and Address of Facility 4739 Baltimore Avenue, Hyattsville, MD 20781		Approximate Interval Between Onset and Death 30 min			
	23a. Pert. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Asystole		Due to (or as a consequence of):		1 hour			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Acute Myocardial infarction		Due to (or as a consequence of):		years			
	Coronary Artery Disease		Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherosclerotic Cardiovascular Disease Hypertension Senile Dementia								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Francis Gasch M.D.		29c. License number D22549		29d. Date signed (Month, Day, Year) 7-15-96				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G. M. Dim, M.D. 6510 Kenilworth Ave Riverdale M.D. 20737								
31. Date filed (Month, Day, Year) JUL 16 1996		32. Registrar's Signature John A. [Signature]						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

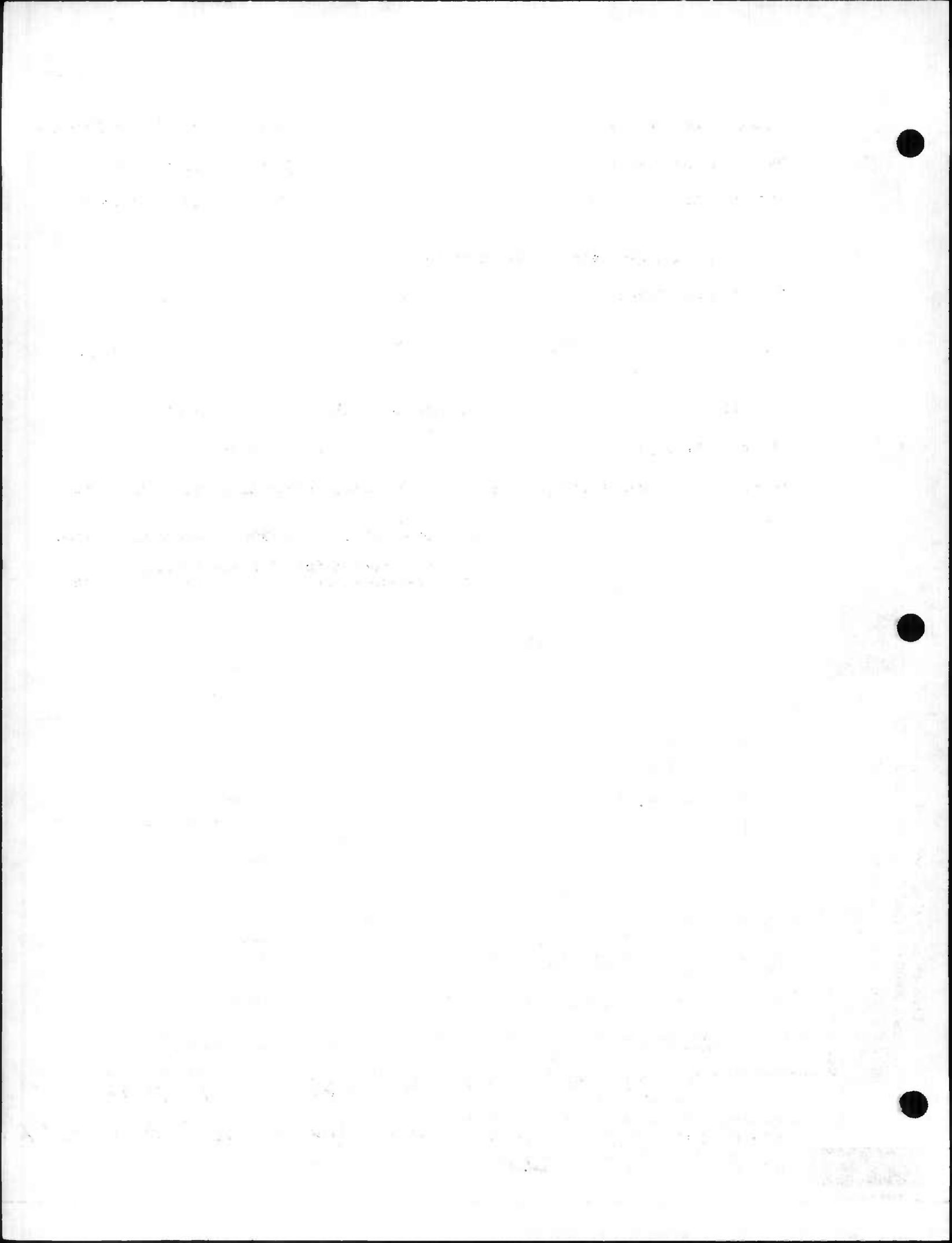
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Amended #2, J.S. DC. 7/16/96

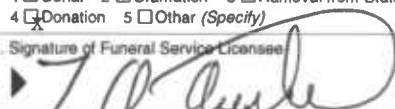
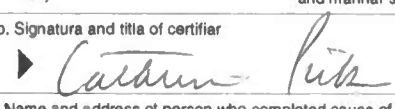
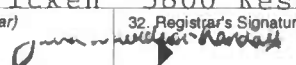
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23124

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CELESTINO LAZZARI						2. Date of Death Month <u>7</u> Day <u>9</u> Year <u>96</u>		3. Time of Death 3:05 AM		
	4a. Facility Name (If not institution, give street and number) 7211 Morrison Drive						4b. City, Town, or Location of Death Greenbelt		4c. County of Death P.G.		
Funeral Director	5. Social Security Number 579-34-2946		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) 3/23/30		9. Birthplace (State or Foreign Country) Wash. D.C.		
	10a. State MD		10b. County Prince Georg.		10c. City, Town or Location Greenbelt		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10e. Street and Number 7211 Morrison Drive		10f. Zip Code 20770		10g. Citizen of What Country? USA							
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesperson		16b. Kind of Business/Industry Self-employed							
17. Father's Name (First, Middle, Last) Charles Lazzari		18. Mother's Name (First, Middle, Maiden Surname) Maria Ferro									
19a. Informant's Name/Relationship (Type, Print) Duley Lezzari wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7211 Morrison Dr. Greenbelt, MD 20770									
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Georgetown Univ. Med		20c. Location - City or Town, State 7/9/06 Wash. D.C.							
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Austin Royster Funeral Home 3605 14th St. NW Wash. D.C. 20010									
23a. Path. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Respiratory arrest</u> Due to (or as a consequence of): b. <u>Metastatic cancer of skin</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number DC 17380		29d. Date signed (Month, Day, Year) 7/16/96					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Catherine Picken 3800 Reservoir Rd. NW Wash. D.C. 20007											
31. Date filed (Month, Day, Year) JUL 16 1996		32. Registrar's Signature 									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23125

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Hattie Hortense Lee

2. Date of Death
Month Day Year
July 3, 19963. Time of Death
1:10 AMFuneral
Director

4a. Facility Name (If not Institution, give street and number)

Allegis of Southern Maryland

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George

5. Social Security Number

578-48-1736

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 24, 1903

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3000 Brothers Street, SE

10f. Zip Code

20032

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

7

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Howard Lee

18. Mother's Name (First, Middle, Maiden Surname)

Nacissus Stewart

19a. Informant's Name/Relationship (Type, Print)

Cherry Blackwell

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8513 Stevenswood Road Baltimore, Maryland 21244

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Potomac Bapt. Church Cem.

Date

7-6-96

20c. Location - City or Town, State

Hague, Virginia

21. Signature of Funeral Service Licensee

Howard A. Carson

22. Name and Address of Facility

Berry O. Waddy Fuenral Home

Route 3 Box 165 Lancaster, Virginia

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Chr. Renal failure

Due to (or as a consequence of):

b. Rectal Vaginal Fistula

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Julia A. Karall

29c. License number

D24535

29d. Date signed (Month, Day, Year)

July 8, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Laxmi N. Berwa MD, 7700 Old Branch Ave. Clinton, MD 20735

31. Date filed (Month, Day, Year)

JUL 15 1996

32. Registrar's Signature

Julia A. Karall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23126

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy D. Melhoff

2. Date of Death

Month
JulyDay
12Year
1996

3. Time of Death

7:00 P.M.

4e. Facility Name (If not institution, give street and number)

Prince George's Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

504 50 9471

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

51

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Nov. 2, 1944

9. Birthplace (State or Foreign Country)

South Dakota

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16310 Bawtry Court

10f. Zip Code

20715

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16e. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Investigative Assistant

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Harold L. Lauer

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy E. Meyer

19e. Informant's Name/Relationship (Type, Print)

Raymond G. Melhoff Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16310 Bawtry Court Bowie Maryland 20715

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Lakemont Memorial Gardens 7/18/96 Davidsonville Md.

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Robert E. Evans, Pres

22. Name and Address of Facility

Robert E. Evans Funeral Home, P.A.

16000 Annapolis Rd. Bowie Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. MASSIVE BILATERAL PULMONARY EMBOLI

15 MINUTES

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. DISSEMINATED LUPUS ERYTHEMATOSUS

2 YEARS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28e. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Nelson G. Goodman

29c. License number

D02193

29d. Date signed (Month, Day, Year)

7/13/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Nelson G. Goodman M.D. 3231 Superior Lane Bowie Maryland 20715

State
Registrar

31. Date filed (Month, Day, Year)

JUL 17 1996

32. Registrar's Signature

Julia Anniston-Randall

Baltimore, Maryland 21215-0020

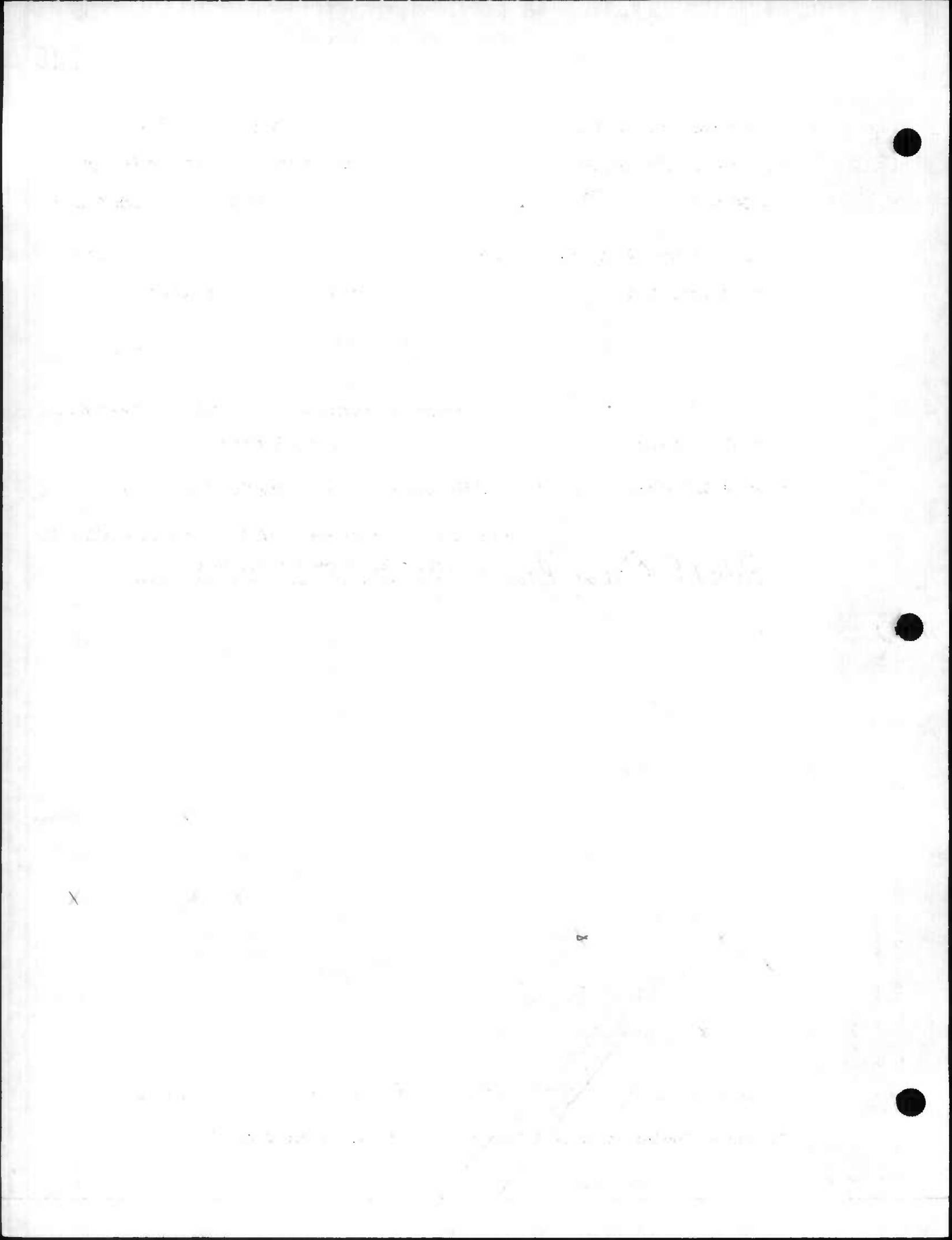
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23127

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CAROLINE A. MONTI

2. Date of Death

Month Day Year
July 16, 1996

3. Time of Death

3:15 AM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

063-20-1935

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 18, 1919

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5306 41st Place

10f. Zip Code

20781

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
9

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Vincent Mellusi

18. Mother's Name (First, Middle, Maiden Surname)

Maria Agnese

19a. Informant's Name/Relationship (Type, Print)

Casimiro Monti / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5306 41st Place, Hyattsville, Maryland 20781

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Cem. July 19, 1996 Silver Spring, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 2078123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Septic Shock

Due to (or as a consequence of):

hours

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Aspiration Pneumonia

Due to (or as a consequence of):

hours

c. Dysphagia

Due to (or as a consequence of):

months

d. Cerebrovascular Disease and Alzheimers

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

MD

29c. License number

D20362

29d. Date signed (Month, Day, Year)

July 16, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Norton Elson 6525 Belcrest Road Hyattsville MD 20782

State
Registrar

31. Date filed (Month, Day, Year)

JUL 18 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23128

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Tony Glenn Messina

2. Date of Death

Month Day Year
July 8, 1996

3. Time of Death

8:30 A.M.

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

217 76 5557

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

37

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 28, 1958

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

XX ☒ Yes ☐ No

10e. Street and Number

12703 Hillmeade Station Drive

10f. Zip Code

20720

10g. Citizen of What Country?

United States

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Hairdresser

16b. Kind of Business/Industry

Cosmetology

17. Father's Name (First, Middle, Last)

Joseph Anthony Messina

18. Mother's Name (First, Middle, Maiden Surname)

Merium Genell Capps

19a. Informant's Name/Relationship (Type, Print)

Genell M. Childs Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12703 Hillmeade Station Drive Bowie Md. 20720

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory 7/9/96

Date

20c. Location - City or Town, State

Alexandria Virginia

21. Signature of Funeral Service Licensee

Robert E. Evans Pres

22. Name and Address of Facility

Robert E. Evans Funeral Home, P.A.
16000 Annapolis Rd. Bowie Md. 2071523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. ACQUIRED IMMUNE DEFICIENCY SYNDROME

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

pancytopenia, anemia, wasting syndrome, leukopenia

fungal pneumonia, cytomegalovirus

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?
☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Lewis Hilliard Dennis

29c. License number

D01499

29d. Date signed (Month, Day, Year)

July 8, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

LEWIS HILLIARD DENNIS, M.D., P.A. 6201 GREENBELT RD. COLLEGE PARK, MD 20740

31. Date filed (Month, Day, Year)

JUL 17 1996

32. Registrar's Signature

John A. H. H. H.

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23129

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PHILLIP MILLS

2. Date of Death

Month Day Year
JULY 12, 1996

3. Time of Death

12:45 AM

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES GENERAL HOSPITAL

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

212-54-3599

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

47

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
SEPT. 5, 1948

9. Birthplace (State or Foreign Country)

WASHINGTON, DC

Usual Residence of Decedent

10a. State

10b. County

MARYLAND PRINCE GEORGES SEAT PLEASANT

10c. City, Town or Location

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7326 JOPLIN STREET

10f. Zip Code

20743

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

XX Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12TH

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ACCOUNTING

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

HARRISON E. MILLS

18. Mother's Name (First, Middle, Maiden Surname)

VIOLA WASHINGTON

19a. Informant's Name/Relationship (Type, Print)

YVONNE SUMNER (SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7326 JOPLIN ST., SEAT PLEASANT, MD 20743

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

NORTHERN VIRGINIA CREM. 07-13-96 ARLINGTON, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Edward M. Dudley

22. Name and Address of Facility

DUDLEY FUNERAL HOME
3200 RHODE ISLAND AVE., MT. RAINIER, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. acquired immune deficiency syndrome

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

chronic leukoplakia pneumonia
working 'spondylitis hips x-rays
ectopic, hypopharyngeal meningitis

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Lewis Dennis, M.D.

29c. License number

101459

29d. Date signed (Month, Day, Year)

July 12, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LEWIS DENNIS, M.D.; 6201 GREENBELT RD. SUITE U17, COLLEGE PARK, MD

31. Date filed (Month, Day, Year)

JUL 16 1996

32. Registrar's Signature

John A. Davidson

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

[Faint, illegible text covering the page, likely bleed-through from the reverse side. The text is too light to transcribe accurately.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23130

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN DEREK NELSON

2. Date of Death

Month Day Year
July 10, 1996

3. Time of Death

4:49 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

278-68-0749

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

36 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 9, 1960

9. Birthplace (State or Foreign Country)

Cincinnati Ohio

Usual Residence of Decedent

10a. State

None

10b. County

None

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3200 16th Street, N.W.

10f. Zip Code

20010

10g. Citizen of What Country?

United States
of America

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
9

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Furrier

16b. Kind of Business/Industry

Fur

17. Father's Name (First, Middle, Last)

Roland Nelson

18. Mother's Name (First, Middle, Maiden Surname)

Mary Jane Kirk

19a. Informant's Name/Relationship (Type, Print)

Roland Nelson /Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1715 Andina Avenue, Cincinnati, Ohio 45237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Spring Grove Cemetery

Date

7/22/96

20c. Location - City or Town, State

Cincinnati, Ohio

21. Signature of Funeral Service Licensee

#M00690

22. Name and Address of Facility

Hall-Jordan Funeral Home

2625 Gilbert Avenue, Cincinnati, Ohio 45206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Acute respiratory Failure

Due to (or as a consequence of):

b. Pneumonia and

Due to (or as a consequence of):

c. Renal Failure

Due to (or as a consequence of):

d. Acquired Immune deficiency Syndrome

Approximate
Interval Between
Onset and Death

one hour

4 days

4 days

Several years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation 6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

MKarim MD

29c. License number

D-18895

29d. Date signed (Month, Day, Year)

July 10, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOBARAK KARIM, 7610 CARROLL AVENUE, TAKOMA PARK, MD 20912

31. Date filed (Month, Day, Year)

JUL 15 1996

32. Registrar's Signature

John D. [Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23131

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT MCCORD

2. Date of Death

Month Day Year
JULY 14 1996

3. Time of Death

8:30 PM

4a. Facility Name (If not institution, give street and number)

SOUTHEAST MARYLAND HOSPITAL

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGE

Funeral
Director

5. Social Security Number

577-72-9954

8. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

43

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 14, 1952

9. Birthplace (State or Foreign Country)

Augusta, GA

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

District of Columbia

Washington

10e. Street and Number

3433 Eads Street, N. E.

10f. Zip Code

20019

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Roofers

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Robert Lee McCord, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Janet Vinson

19a. Informant's Name/Relationship (Type, Print)

Martha J. Cunningham

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3433 Eads Street, N.E., Washington, D.C. 20019

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Harmony Memorial Park

Date

7/18/96

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

STEWART FUNERAL HOME, Inc.

4001 Benning Road, N.E., Washington, D. C.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. AIDS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 years.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

bilateral pneumonia.

cerebrovascular accident.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sam TELLAWI

29c. License number

D34274

29d. Date signed (Month, Day, Year)

7-15-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ESSAM TELLAWI

7700 OLD BRANCH Ave. Clinton MD 20735

31. Date filed (Month, Day, Year)

JUL 19 1996

32. Registrar's Signature

John Andrew Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23132

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES R. MCQUILLEN

2. Date of Death

Month JULY 13, 1996

3. Time of Death

11:00 PM

4a. Facility Name (If not institution, give street and number)

7224 Kidmore Lane

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

220-16-3653

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

August 22, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Lanham

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7224 Kidmore Lane

10f. Zip Code

20706

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1941-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:
Caucasian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Foreman

16b. Kind of Business/Industry

Amtrak

17. Father's Name (First, Middle, Last)

Joseph McQuillen

18. Mother's Name (First, Middle, Maiden Summa)

Ruie Hawkins

19a. Informant's Name/Relationship (Type, Print)

Ann E. MCQUILLEN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7224 Kidmore Lane, Lanham, MD 20706

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Funeral Home

Date

7-15-96

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

Richard Rendon

22. Name and Address of Facility

Rendon/Hale Funeral Home
9013 Annapolis Road, Lanham, MD 20706

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

-Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Harvey Katzen

29c. License number

D20352

29d. Date signed (Month, Day, Year)

7/15/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harvey Katzen 8926 Woodland Rd (Prince, MD)

31. Date filed (Month, Day, Year)

JUL 15 1996

32. Registrar's Signature

Julia A. ...

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) (AKA: Dominick Thomas Mirandi) DOMINIC THOMAS MIRANDI				2. DATE OF DEATH MONTH DAY YEAR JULY 2 1996		3. TIME OF DEATH 7:41 A.M.	
4. SOCIAL SECURITY NUMBER 012-14-8009		5. SEX 1 X M 2 F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1915 November 16, 11	
9a. FACILITY NAME (If not institution, give street and number) Fallston Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Fallston		9c. COUNTY OF DEATH Harford County	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Harford County		10c. CITY, TOWN OR LOCATION Joppa		10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
10e. STREET AND NUMBER 507 Joppa Farm Road				10f. ZIP CODE 21085		10g. CITIZEN OF WHAT COUNTRY? United States of America	
11. MARITAL STATUS 1 X Never Married 2 X Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Official Scorekeeper		16b. KIND OF BUSINESS/INDUSTRY Professional Golf Association			
17. FATHER'S NAME (First, Middle, Last) Matteo Mirandi				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annunziata Geurriero			
19a. INFORMANT'S NAME (Type/Print) Helen Ambrose Mirandi				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 507 Joppa Farm Road, Joppa, Maryland			
20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) North Beverly Cemetery 7/6 1996		20c. LOCATION — City or Town, State Beverly, Massachusetts			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald Payne Cousar #M00690		22. NAME AND ADDRESS OF FACILITY Lee Moody & Russell Funeral Home, Inc. #9 Dane Street, Beverly, Massachusetts					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Asystole with severe hypotension Approximate interval between Onset and Death 5 min					
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. Severe coronary artery disease 20 yrs.					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cardiomyopathy, Aortic aneurysm, Severe chronic obstructive lung disease							
24a. WAS AN AUTOPSY PERFORMED? 1 X YES 2 NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 X YES 2 NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES X NO UNCERTAIN							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. MANNER OF DEATH 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY N/A M		28c. INJURY AT WORK? 1 X YES 2 NO	
		28d. DESCRIBE HOW INJURY OCCURRED N/A		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIED (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Consultant				29c. LICENSE NUMBER D-16444		29d. DATE SIGNED (Month, Day, Year) JULY 2nd 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VIJAY S. NAIR - 2112 BELAIR ROAD - Fallston - MD 21047							
31. DATE FILED (Month, Day, Year) JUL 08 1996		32. REGISTRAR'S SIGNATURE John Andrew Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23134

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JUNIOR THOMAS

NEWMAN

2. Date of Death

Month Day Year
JULY 12 1996

3. Time of Death

3:33P.M.

4a. Facility Name (If not institution, give street and number)

FORT WASHINGTON MEDICAL CENTER

4b. City, Town, or Location of Death

FORT WASHINGTON

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

220-28-5710

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 4, 1932

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Landover

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1922 Columbia Avenue

10f. Zip Code

20785-3943

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Negro

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Maintenance Worker

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Robert Newman

18. Mother's Name (First, Middle, Maiden Surname)

Eva Butler

19a. Informant's Name/Relationship (Type, Print)

Barbara H. Newman - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6503 Wilburn Drive. Capital Heights, Maryland 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Quantico National Cemetery 7/22/96 Triangle, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

STEWART FUNERAL HOME, INC.

4001 Benning Road, N. E., Washington, D. C.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Multiple Injuries
Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☒ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

7-12-96

28b. Time of injury

1457 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Passenger in vehicle struck by truck
I-95 at Rte 210 over Hill

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

STREET

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
2 ☒ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier

ANDIXON

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 13, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 19 1996

32. Registrar's Signature

John Anderson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Amended #25, P.D. S.C., 7/16/96.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23135

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen M. Ontrich

2. Date of Death

Month Day Year
July 12, 1996

3. Time of Death

5:59 P.M.

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

420-46-3594

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

59

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 5, 1937

9. Birthplace (State or Foreign Country)

California

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Largo

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10135 Prince Place # 201

10f. Zip Code

20774

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Clyde Blair

18. Mother's Name (First, Middle, Maiden Surname)

Irwinna Blankenship

19a. Informant's Name/Relationship (Type, Print)

John H. Ontrich - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10135 Prince Pl. #201, Largo, Maryland 20774

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Washington National Cemetery 7/16/96 Suitland, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

George P. Kalas

22. Name and Address of Facility

George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Md. 2074523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. CHRONIC obstructive lung disease years.

Due to (or as a consequence of):

b. Bronchial asthma years.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

congestive heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Cesar Soriano Jr MD

29c. License number

D 14468

29d. Date signed (Month, Day, Year)

7/13/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CESAR SORIANO JR. MD

119 CAPITOL HTS BLVD
Capitol Heights MD 20743

31. Date filed (Month, Day, Year)

JUL 16 1996

32. Registrar's Signature

*John Anderson-Randall*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be attached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23136

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth O'Brien				2. Date of Death Month July Day 9 Year 1996		3. Time of Death 7:00 AM		
	4a. Facility Name (If not institution, give street and number) 2505 Jennings Road				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 026-20-8915		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 31, 1903		
	9. Birthplace (State or Foreign Country) Massachusetts		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 2505 Jennings Road		10f. Zip Code 20902		10g. Citizen of What Country? United States of America	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Principal		16b. Kind of Business/Industry Education		17. Father's Name (First, Middle, Last) William O'Brien		18. Mother's Name (First, Middle, Maiden Surname) Delia Boland	
19a. Informant's Name/Relationship (Type, Print) Judith McPherson - Niece		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2505 Jennings Road Silver Spring, Maryland		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Bernard's Cemetery		20c. Location - City or Town, State July 13 1996 Fitchburg, MA	
21. Signature of Funeral Service Licensee #M00690 Howard A. Carson		22. Name and Address of Facility Smith-Mallahy Funeral Home 243 Water Street, Fitchburg, MA 01420		23a. Per 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Conjunctive heart failure		Approximate Interval Between Onset and Death weeks			
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Lila McConnell		29c. License number D39456		29d. Date signed (Month, Day, Year) July 10, 1996		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lila McConnell, M.D. 5530 Wisconsin Avenue Chevy Chase, Maryland	
31. Date filed (Month, Day, Year) JUL 15 1996		32. Registrar's Signature Jane M. Randall							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23137

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GWENDOLYN W. OREE

2. Date of Death

Month Day Year
JULY 07 1996

3. Time of Death

2130 a.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

095-44-4579

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

43 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept 9 1952

9. Birthplace (State or Foreign Country)

Columbia SC

Usual Residence of Decedent

10a. State
Maryland

10b. County

10c. City, Town or Location

Bethesda, Maryland

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

4808 Moorland Lane #601

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Advertising Executive

16b. Kind of Business/Industry

Advertising

17. Father's Name (First, Middle, Last)

Oliver Oree, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Reatha Deloach

19a. Informant's Name/Relationship (Type, Print)

Reatha Harrison/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3919 Hampden Street Kensington, Maryland 20895

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Harmony Memorial Park

Date

7/11

20c. Location - City or Town, State

Landover, MD

21. Signature of Funeral Service Licensee

Alex S. Pope Jr.

22. Name and Address of Facility

Alexander S. Pope Funeral Homes

5538 Marlboro Pike Forestville, MD. 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)e. *Cerebrovascular Accident*
Due to (or as a consequence of):

1 day

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. *Hypertension*
Due to (or as a consequence of):

2 years

c. *Diabetes mellitus*
Due to (or as a consequence of):

17 years

d. *End Stage Renal Disease*

3 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia, diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

James H. Hays, Jr., MD

29c. License number

04525

29d. Date signed (Month, Day, Year)

8 July 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4915 Auburn Ave, Bethesda, Md 20814

31. Date filed (Month, Day, Year)

JUL 12 1996

32. Registrar's Signature

*Jubia Anderson-Randall*State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

6 0/6 Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23138

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DWAYNE NAVELL PEARSON

2. Date of Death
Month Day Year

JULY 15, 1996

3. Time of Death

1950PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

4441 23RD PARKWAY APT. #102

4b. City, Town, or Location of Death

TEMPLE HILLS

4c. County of Death

PRINCE GEORGES

5. Social Security Number

212-11-3378

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

26

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 4, 1969

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State
Maryland10b. County
Prince George's10c. City, Town or Location
Oxon Hill

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4441 23rd Parkway

10f. Zip Code

20745

10g. Citizen of What Country?

United States

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
Black15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Mail Handler

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

John E. Pearson, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Frances Spencer

19a. Informant's Name/Relationship (Type, Print)

Frances Pearson - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4705 Addison Drive, Oxon Hill, Maryland 20745

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

7/20/96

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

STEWART FUNERAL HOME, Inc.

4001 Benning Road, N. E., Washington, D. C.

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. Gunshot wound of the head
Due to (or as a consequence of):Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. _____
Due to (or as a consequence of):c. _____
Due to (or as a consequence of):d. _____
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?

Head only

☒ Yes ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?☒ Yes ☐ No25. Was case referred to medical
examiner?
☒ Yes ☐ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

28. Place of Death (Check only one)

Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☒ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)

7-15-96

28b. Time of
Injury

1950

28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

Self inflicted

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

Home

28f. Location (Street and Number or Rural Route Number,
City or Town, State) 4441 23rd PKwy, #102
Prince Georges County, MD29a. Certifier
(Check only
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis J. Chute MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 16, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dennis J. Chute MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 19 1996

32. Registrar's Signature

*Juba Davidson-Randall*State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23139

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DWAYNE

ANTHONY

POWELL

2. Date of Death

Month

Day

Year

JULY

12,

1996

3. Time of Death

6:20 am

4a. Facility Name (If not institution, give street and number)

WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-76-7525

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

38

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 9, 1957

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6500 Riggs Road

10f. Zip Code

20783

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Joseph R. Powell

18. Mother's Name (First, Middle, Maiden Surname)

Audrey Mae Mason

19a. Informant's Name/Relationship (Type, Print)

Peggy L. Roberson - Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3016 Q Street, S. E., Washington, D.C. 20020

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Maryland National

Memorial Park

Date

7/17/96

20c. Location - City or Town, State

Laurel, MD

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

STEWART FUNERAL HOME, Inc.

4001 Benning Road, N.E., Washington, D.C.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e.

AIDS

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

8 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner as stated.

29b. Signature and title of certifier

Tony P. Kannarkat MD

29c. License number

D-20062

29d. Date signed (Month, Day, Year)

JULY 14, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TONY P. KANNARKAT, 8201 16th St SILVER SPRING MARYLAND 20910

31. Date filed (Month, Day, Year)

JUL 16 1996

32. Registrar's Signature

Julia Stewart-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23140

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mae Elizabeth Reed				2. Date of Death Month July Day 23 Year 1996		3. Time of Death 03:55 AM		
	4a. Facility Name (If not institution, give street and number) Lorien Nursing & Rehabilitation Center				4b. City, Town, or Location of Death Columbia		4c. County of Death Howard County		
Funeral Director	5. Social Security Number 397 07 4934		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov/08/1915	9. Birthplace (State or Foreign Country) Wisconsin	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD	10b. County Anne Arundel		10c. City, Town or Location Crownsville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 1628 Wyatts Ridge			10f. Zip Code 21032		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collegiate (1-4 or 5+)		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Ghorman E. Cody				18. Mother's Name (First, Middle, Maiden Surname) Anna Goetz				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Barbara Reed (daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1628 Wyatts Ridge/Crownsville MD 21032				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Data 7/23		20c. Location - City or Town, State Alexandria VA		
	21. Signature of Funeral Service Licensee <i>Melanie Wilhelm-Nelson</i>				22. Name and Address of Facility Advent Funeral & Cremation Services Annapolis MD 21401				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. dementia - probable Alzheimer's years Dua to (or as a consequence of): b. Dua to (or as a consequence of): c. Dua to (or as a consequence of): d. Dua to (or as a consequence of):								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. High Blood pressure						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Robert L. ...</i>		29c. License number D31575		29d. Date signed (Month, Day, Year) July 23, 1996		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KODRUB ETZ 9501 Old Annapolis Rd Ellicott City MD 21042	
31. Date filed (Month, Day, Year) JUL 24 1996		32. Registrar's Signature <i>Julia Davidson-Randall</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23141

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) Hugh Robert Reilly				2. Date of Death Month July Day 8 Year 1996		3. Time of Death 7:00 P.M.	
4a. Facility Name (If not institution, give street and number) Bowie Health Center				4b. City, Town, or Location of Death Bowie		4c. County of Death Prince George's	
5. Social Security Number 210 12 4065		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 6, 1926	
9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Bowie	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 12611 Kavanaugh Lane		10f. Zip Code 20715		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cartographer		16b. Kind of Business/Industry U.S. Government		17. Father's Name (First, Middle, Last) Hugh Robert Reilly	
18. Mother's Name (First, Middle, Maiden Surname) Sarah Bell		19a. Informant's Name/Relationship (Type, Print) Juanita G. Reilly Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12611 Kavanaugh Lane Bowie Md. 20715		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery		20c. Date 7/12/96		20d. Location - City or Town, State Cheltenham Md.		21. Signature of Funeral Service Licensee Robert E. Evans	
22. Name and Address of Facility Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SYNCOPE Due to (or as a consequence of): ischemic heart disease Myocardial infarction		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Myocardial infarction		23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
29b. Signature and title of certifier Dr. [Signature] MD		29c. License number D-19252		29d. Date signed (Month, Day, Year) 7/9/96		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ROBERTO A DEPETRIS MD 14300 GALLANT Fox LA #122 Bowie Md 20715	
31. Date filed (Month, Day, Year) JUL 17 1996		32. Registrar's Signature John [Signature]		State Registrar			

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23142

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDNA A. SPRIGGS

2. Date of Death

Month Day Year
JULY 21 1996

3. Time of Death

1625

4a. Facility Name (If not institution, give street and number)

ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

579-01-9156

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

95

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MARCH 26 1901

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State
MARYLAND10b. County
ANNE ARUNDEL10c. City, Town or Location
LOTHIAN

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1147 MARLBORO ROAD

10f. Zip Code

20711

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

7th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

COOK

16b. Kind of Business/Industry

RESTAURANT

17. Father's Name (First, Middle, Last)

THOMAS E. DAVIS, SR.

18. Mother's Name (First, Middle, Maiden Surname)

JANE OWENS

19a. Informant's Name/Relationship (Type, Print)

MAGGIE SMITH (NEICE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1400 MARLBORO ROAD LOTHIAN, MD. 20711

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MOSES CEMETERY

Date

7/25/96

20c. Location - City or Town, State

DRURY, MD.

21. Signature of Funeral Service Licensee

Harry J. Reese

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.

821 WEST STREET ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Myocardial infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

mins

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypokalemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ann C. Marney, M.D.

29c. License number

D44465

29d. Date signed (Month, Day, Year)

7/22/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ann C. Marney, M.D. 900 Bestgate Road, Annapolis, MD 21401

31. Date filed (Month, Day, Year)

JUL 23 1996

32. Registrar's Signature

Julia Davidson-Rendell

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23143

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Clarence W. Stephenson				2. Date of Death Month 07 Day 17 Year 96		3. Time of Death 3:30 AM	
	4a. Facility Name (If not institution, give street and number) Allegis of Southern Maryland				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 263-05-9734		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) 07-23-17	
	9. Birthplace (State or Foreign Country) Georgia		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Upper Marlboro	
To Be Completed by Funeral Director	10e. Street and Number 16301 Village Drive West		10f. Zip Code 20772		10g. Citizen of What Country? USA		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 4/24/41 10/12/45		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sky Cap		16b. Kind of Business/Industry Private			
	17. Father's Name (First, Middle, Last) Dozier Stephenson				18. Mother's Name (First, Middle, Maiden Surname) Laura Gaskin			
	19a. Informant's Name/Relationship (Type, Print) Laura Miller/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16301 Village Drive W., Upper Marlboro, MD 20772			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Memorial Park		20c. Date 7/25/96		20d. Location - City or Town, State West Palm Beach, FL	
	21. Signature of Funeral Service Licensee Nancy A. Percentie				22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, MD 20785			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. carcinoma of bladder metastasis Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death months							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Peripheral vascular dz.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier SMS				29c. License number D46478		29d. Date signed (Month, Day, Year) 7-17-96		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Suresh A. Patel 7501 Summits Rd. #302, Clinton MD 20735								
31. Date filed (Month, Day, Year) JUL 19 1996				32. Registrar's Signature Juba Thompson-Randall				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23144

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MERYL THOMAS MOODY SHINGLER

2. Date of Death

Month
JulyDay
11Year
1996

3. Time of Death

2:40 A.M.

4a. Facility Name (If not institution, give street and number)

LIVINGSTON HEALTH CARE CENTER

4b. City, Town, or Location of Death

FT. WASHINGTON

4c. County of Death

PRINCE GEORGES

5. Social Security Number

248-36-4276

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov 8, 1926

9. Birthplace (State or Foreign Country)

Orangeburg, SC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Suitland, Maryland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3415 Swann Road

10f. Zip Code

20746

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Restaurateur

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Shelley Thomas

18. Mother's Name (First, Middle, Maiden Surname)

Almar Gilyard

19a. Informant's Name/Relationship (Type, Print)

Jannet S. Alexander/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3415 Swann Road Suitland, Maryland 20746

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

7/16

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

Alex S. Pope Jr. M859

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOMES
5538 Marlboro Pike, Forestville, Md. 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic cardiovascular disease

Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Multiple strokes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Philip Wisofsky

29c. License number

D18545

29d. Date signed (Month, Day, Year)

July 12, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Philip Wisofsky, M.D. 700 Old Line Center Suite 207, Waldorf, Md.

31. Date filed (Month, Day, Year)

JUL 17 1996

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

8 1/7

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23145

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James L. Sterling				2. Date of Death Month Day Year July 11 1996		3. Time of Death 4:30 P.M.	
	4a. Facility Name (If not institution, give street and number) 14589 London Lane				4b. City, Town, or Location of Death Bowie		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 097 28 2632		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) April 4, 1939	
	9. Birthplace (State or Foreign Country) Ohio		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Bowie	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 14589 London Lane		10f. Zip Code 20715		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 63-90		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager		16b. Kind of Business/Industry Brown & Root Construction			
	17. Father's Name (First, Middle, Last) Frank R. Sterling				18. Mother's Name (First, Middle, Maiden Surname) Bernadine Cummings			
	19a. Informant's Name/Relationship (Type, Print) Patricia Sterling Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14589 London Lane Bowie Maryland 20715			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State Alexandria Va.		20d. Date 7/12/96	
	21. Signature of Funeral Service Licensee Robert E. Evans Pres.				22. Name and Address of Facility Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Physician /Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier John C. Byrd				29c. License number VA 001049358		29d. Date signed (Month, Day, Year) 7/12/96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John C. Byrd, Wd 78 WRAnc, Washington D.C.							
31. Date filed (Month, Day, Year) JUL 17 1996		32. Registrar's Signature John C. Byrd						

96-3861-510

B.K.S

96-147

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23146

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMAL RAHIM STRINGFELLOW				2. Date of Death Month Day Year JULY 12, 1996		3. Time of Death 0155 AM	
	4a. Facility Name (If not institution, give street and number) 4000 BLK. SOUTH CLARE ROAD				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 578-98-0771		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 26 Yrs.		8. Date of Birth (Month, Day, Year) 04-10-70	
	9. Birthplace (State or Foreign Country) WASH. DC		10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 8711 Carrol Ave		10f. Zip Code 20903		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Auto mechanic		16b. Kind of Business/Industry Private			
	17. Father's Name (First, Middle, Last) Jessie Stringfellow Jr				18. Mother's Name (First, Middle, Maiden Surname) Lillie Gilmore			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Angelica Barreto (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8711 Carrol Ave S-S. Md. 20903			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rock Creek		20c. Location - City or Town, State 7/19/96 WASH. DC		20d. Date	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee James Edwards				22. Name and Address of Facility Hodges + Edwards 3910 Silver Hill Rd			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gunshot wound of head Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death			
Division of Vital Records, P.O. Box 68760	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) ROADWAY					
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) UNK		28b. Time of Injury UNK M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred Subject shot		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) UNK		28f. Location (Street and Number or Rural Route Number, City or Town, State) UNK			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier John Locke				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) JULY 12, 1996	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Locke, MD 111 Penn Street, Baltimore, Maryland 21201							
State Registrar	31. Date filed (Month, Day, Year) JUL 15 1996				32. Registrar's Signature John Andrew Randall			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23147

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CARL M. SHOFFLER				2. Date of Death Month Day Year JULY 13 1996		3. Time of Death 2:58p
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death
Funeral Director	5. Social Security Number 206 34 6087	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 17, 1945	9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Bowie		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 2930 Tallow Lane			10f. Zip Code 20715		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 65-69		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Intelligence Officer		16b. Kind of Business/Industry Prince George's Co. Fire Department		
	17. Father's Name (First, Middle, Last) Allen Shoffler			18. Mother's Name (First, Middle, Maiden Summa) Eleanor Smith			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Helene Shoffler Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2930 Tallow Lane Bowie Maryland 20715			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Memorial Gardens		20c. Location - City or Town, State 7/20/96 Davidsonville Md.		
	21. Signature of Funeral Service Licensee Robert E. Evans, Pres			22. Name and Address of Facility Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) a. Acute Respiratory Distress Syndrome (ARDS) Due to (or as a consequence of): b. pancreatitis Due to (or as a consequence of): c. Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death approx 18 days 20 days
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes, obesity, hypertension						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
State Registrar	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of injury M		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Simon C. Mears, MD		29c. License number 00016		29d. Date signed (Month, Day, Year) July 13 th , 1996
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Simon C. Mears, Johns Hopkins Hospital						
31. Date filed (Month, Day, Year) JUL 17 1996		32. Registrar's Signature John A. Randall					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23148

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thelma L. Stehr

2. Date of Death

June 21 1996

3. Time of Death

6:15 PM

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

579 03 0470

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 4, 1907

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Crofton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1664 Carlyle Drive

10f. Zip Code

21114

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Telephone Operator

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

William Woodard

18. Mother's Name (First, Middle, Maiden Surname)

Clara Davis

19a. Informant's Name/Relationship (Type, Print)

Henry Stehr Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3912 Croydon Lane Bowie Maryland 20715

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Cedar Hill Cemetery 7/13/96

Date

20c. Location - City or Town, State

Suitland Maryland

21. Signature of Funeral Service Licensee

Robert E. Evans, Pres.

22. Name and Address of Facility

Robert E. Evans Funeral Home, P.A.

16000 Annapolis Rd. Bowie Md. 20715

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. Cerebrovascular Accident
Due to (or as a consequence of):Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident
3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

31602

29d. Date signed (Month, Day, Year)

June 28, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

George Cavanagh, M.D. 1655 Crofton Boulevard Crofton Md. 21114

State
Registrar

31. Date filed (Month, Day, Year)

JUL 17 1996

32. Registrar's Signature

Julia Shepherd Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23149

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES B. SMITH

2. Date of Death

Month Day Year
JUNE 21, 1996

3. Time of Death

9:56 AM

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES COMMUNITY HOSPITAL

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES

5. Social Security Number

236-48-5049

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JAN 3, 1933

9. Birthplace (State or Foreign Country)

WEST VIRGINIA

Usual Residence of Decedent

10a. State

NA

10b. County

NA

10c. City, Town or Location

WASHINGTON, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

136 R Street, N.E.

10f. Zip Code

20002

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SANITARY ENGINEER

16b. Kind of Business/Industry

D.C. GOVERNMENT

17. Father's Name (First, Middle, Last)

JAMES B. SMITH

18. Mother's Name (First, Middle, Maiden Surname)

AUDRE SHAZOR

19a. Informant's Name/Relationship (Type, Print)

JEWEL STEPHENS (SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

136 R St., N.E. Washington, D.C. 20002

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

HARMONY MEMORIAL PARK

Date

7/20

20c. Location - City or Town, State

Landover, MD.

21. Signature of Funeral Service Licensee



M859

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOMES
5538 Marlboro Pike, Forestville, Md. 2074723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Atherosclerosis

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

d.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier



29c. License number

D2675

29d. Date signed (Month, Day, Year)

6/22/96

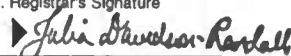
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Hector K. Collison MD 8401 Colesville Road, Suite 310, Silver Spring, Md.

31. Date filed (Month, Day, Year)

JUL 19 1996

32. Registrar's Signature

State
Registrar

6 2/4

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

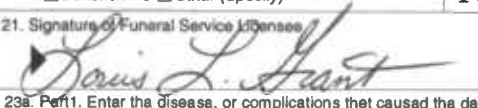
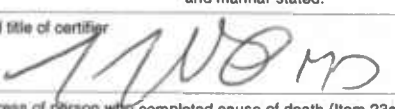
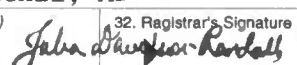
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23150

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DAISY NOLA VALENTINE				2. Date of Death Month July Day 16 Year 1996		3. Time of Death 10:15 a.m.	
	4a. Facility Name (If not institution, give street and number) 2813 Beach Drive				4b. City, Town, or Location of Death Huntingtown		4c. County of Death Calvert	
Funeral Director	5. Social Security Number 577-09-2321	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan 3 1912		9. Birthplace (State or Foreign Country) Kentucky
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Washington, DC.				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 109 4th Street S.E.		10f. Zip Code 20003		10g. Citizen of What Country? United States			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor		16b. Kind of Business/Industry U.S. Gov't.			
	17. Father's Name (First, Middle, Last) Harry Cecil Valentine				18. Mother's Name (First, Middle, Maiden Surname) Bessie Blanton			
	19a. Informant's Name/Relationship (Type, Print) Esther A. Ritchie, Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2813 Beach Dr. Huntingtown, Maryland 20639			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery		20c. Location - City or Town, State 7-19-96		Brentwood, Maryland	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Ft. Lincoln F.H. Inc. 3401 Bladensburg Rd. Brentwood, Maryland					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Endstage Cardiomyopathy Due to (or as a consequence of): b. Conjunctive Heart Failure Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier 				29c. License number D33123		29d. Date signed (Month, Day, Year) 7-16-96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan Lowenthal, MD Dunkirk, MD 20754							
31. Date filed (Month, Day, Year) JUL 18 1996								
32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

2. The second part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

3. The third part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

4. The fourth part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

5. The fifth part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

6. The sixth part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

7. The seventh part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

8. The eighth part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

9. The ninth part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

8/13/96 t.t

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARK JAMES VONDERHAAR				2. Date of Death Month JULY Day 01 Year 1996				3. Time of Death 0515 AM				
	4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL E.R.				4b. City, Town, or Location of Death GLEN BURNIE				4c. County of Death ANNE ARUNDEL				
Funeral Director	5. Social Security Number 408-80-8188		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 36 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 10, 1959		9. Birthplace (State or Foreign Country) Kentucky				
	Usual Residence of Decedent												
To Be Completed by Funeral Director	10a. State Virginia		10b. County Roanoke		10c. City, Town or Location Salem				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number 5048 Cherokee Drive				10f. Zip Code 24153		10g. Citizen of What Country? United States						
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Foreman				16b. Kind of Business/Industry Consolidated Roofing				
	17. Father's Name (First, Middle, Last) James C. Vonderhaar				18. Mother's Name (First, Middle, Maiden Surname) Beverly M. Kuechler								
	19a. Informant's Name/Relationship (Type, Print) Jim Vonderhaar - Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5048 Cherokee Drive Salem, Virginia 24153								
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sherwood Memorial Park		Date 7-8-96		20c. Location - City or Town, State Salem, Virginia						
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility John M. Oakey & Son 305 Boulevard Salem, Virginia 24153								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. NARCOTIC INTOXICATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate interval Between Onset and Death		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
										24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 7-1-96		28b. Time of Injury UNKNOWN M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred UNKNOWN		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) UNKNOWN		28f. Location (Street and Number or Rural Route Number, City or Town, State) UNKNOWN	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. Signature and title of certifier 						29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) JULY 01, 1996					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201													
State Registrar		31. Date filed (Month, Day, Year) JUL 15 1996		32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

8/16/96

Spelling of Last Name, it was change by F. H.
MEO was contacted OK!

Lonley

A amended # 98-100
AH

96 23152

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM B. WALLING				2. DATE OF DEATH MONTH DAY YEAR JULY 16, 1996		3. TIME OF DEATH 4:20 PM	
4. SOCIAL SECURITY NUMBER 579-26-5664		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec 23 1926	
9a. FACILITY NAME (If not institution, give street and number) Perry Point Veterans Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Perry Point		9c. COUNTY OF DEATH Cecil	
10a. STATE MD				10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Perry Point	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER VA Maryland Health Care System / Point				10f. ZIP CODE 21902		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) File Clerk		15b. KIND OF BUSINESS/INDUSTRY U.S. Army Map Service	
17. FATHER'S NAME (First, Middle, Last) James J. Wallings, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Cook			
19a. INFORMANT'S NAME (Type/Print) Katherine A. Hoffman-Niece				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12401 Ranson Drive Glen Dale, MD 20769-8960			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation — 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fairfax Memorial Park 7/19/96		20c. LOCATION — City or Town, State Fairfax, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE							
DUE TO (OR AS A CONSEQUENCE OF):							
b. RESPIRATORY FAILURE							
DUE TO (OR AS A CONSEQUENCE OF):							
c. 							
DUE TO (OR AS A CONSEQUENCE OF):							
d. 							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D40723		29d. DATE SIGNED (Month, Day, Year) July 16, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KARITHANOM ISAAC, M.D., DEPT. OF VETERANS AFFAIRS MEDICAL CENTER, PERRY POINT.							
31. DATE FILED (Month, Day, Year) JUL 23 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 23153

Reg. No.

3 0/3

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and the Funeral Director, page 2 should be detached for use as the burial-transit certificate.

3

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) VIOLET WILSON		2. Date of Death Month JULY Day 17 Year 1996		3. Time of Death 1:15 AM	
4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital		4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George	
5. Social Security Number 218-16-2046		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 76 Yrs.	
8. Date of Birth (Month, Day, Year) Nov 14, 1919		9. Birthplace (State or Foreign Country) P.G. Cnty MD			
Usual Residence of Decedent					
10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location Clinton, Maryland	
10d. Inside City Limits 1 Yes 2 No					
10e. Street and Number 4701 Plata Street		10f. Zip Code 20735		10g. Citizen of What Country? United States	
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 Yes 2 No	
14. Race - American Indian, Black, White, etc. Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic Worker		16b. Kind of Business/Industry Private	
17. Father's Name (First, Middle, Last) Ignatius Diggs		18. Mother's Name (First, Middle, Maiden Surname) Barbara Brooks			
19a. Informant's Name/Relationship (Type, Print) Camilla Allen/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4701 Plata Street Clinton, Maryland 20735			
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		20c. Location - City or Town, State Clinton, Maryland	
21. Signature of Funeral Service Licensee Alex. Pope Jr.		22. Name and Address of Facility Alexander S. Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 20747			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Bilateral Pneumonia					Approximate Interval Between Onset and Death 3 Days
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Multi Infarct Dementia					23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
24a. Was an autopsy performed? 1 Yes 2 No					24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify)			
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. Date of Injury (Month, Day, Year) 7/20		28b. Time of Injury M	
28c. Injury at Work? 1 Yes 2 No		28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier Marlie Takhar M.D.		29c. License number D 46747		29d. Date signed (Month, Day, Year) 7-17-1996	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANBIR TALKHAN 7700 OLD BRANCTT Avenue Clinton Maryland 20735					
31. Date filed (Month, Day, Year) JUL 19 1996		32. Registrar's Signature John Anderson-Rodall			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23154

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Watson

2. Date of Death

Month Day Year
July 10, 1996

3. Time of Death

5:00 PM

4a. Facility Name (If not Institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

577-66-3831

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
01 18 48

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Landover

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3120 75th Avenue #102

10f. Zip Code

20785

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
11th

College (1-4 or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Porter

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Claude Watson Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Novella Hunter

19a. Informant's Name/Relationship (Type, Print)

Loretta Watson/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3120 75th Avenue #102, Landover MD 20785

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

7/13/96

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perentie

22. Name and Address of Facility

J. B. Jenkins Funeral Home
7474 Landover Road, Landover MD 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Brain Stem Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James Cateris

29c. License number

030318

29d. Date signed (Month, Day, Year)

7/10/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Cateris, MD, 3001 Hospital Drive Cheverly Md 20785

31. Date filed (Month, Day, Year)

JUL 15 1996

32. Registrar's Signature

James Cateris

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23155

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARION C. J. WOOD

2. Date of Death

Month
JulyDay
10,Year
1996

3. Time of Death

8:30 P.M.

4a. Facility Name (If not institution, give street and number)

9781 Goodluck Road #2

4b. City, Town, or Location of Death

Lanham-Seabrook

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

578-42-2537

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Aug. 31, 1928

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Lanham-Seabrook

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9781 Goodluck Road #2

10f. Zip Code

20706

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Communication Operator

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Henry Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Elsie Johnson

19a. Informant's Name/Relationship (Type, Print)

Karen J. Brooks - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4513 Romlon Street #2, Beltsville, MD 20705

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland National Memorial Park

Date

7/16/96

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

STEWART FUNERAL HOME, Inc.

4001 Benning Road, N.E., Washington, D. C.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Peritoneal carcinomatosis

Approximate Interval Between Onset and Death

4 mos.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): Metastatic gallbladder carcinoma

8 mos.

Due to (or as a consequence of): Primary gallbladder cancer

16 mos.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Intestinal obstruction

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Lawrence S. Lessin, M.D.

29c. License number

DC 4811

29d. Date signed (Month, Day, Year)

July 11, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAWRENCE S. LESSIN, M.D., 110 IRVING ST. NW, WASHINGTON, DC 20010

31. Date filed (Month, Day, Year)

JUL 16 1996

32. Registrar's Signature

John A. ...

State
Registrar

Baltimore, Maryland 21215-0020

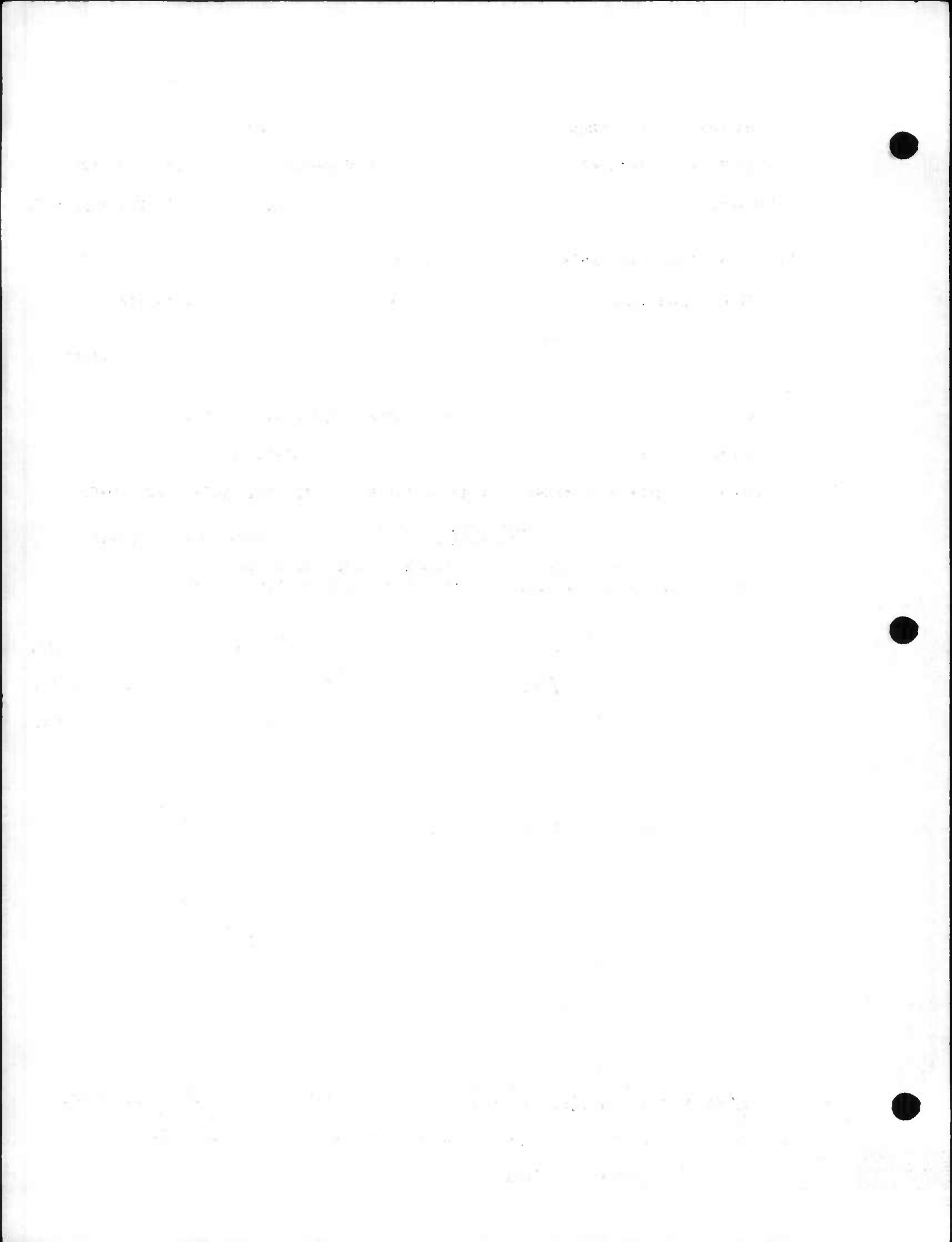
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23156

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Nita Allen Wilkinson

2. Date of Death

Month Day Year
July 10 19963. Time of Death
5:30 AM

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

231-28-9571

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 20, 1913

9. Birthplace (State or Foreign Country)

Newport News Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Lanham

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8511 Brae Brook Drive

10f. Zip Code

20706

10g. Citizen of What Country?

United States
of America

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

John Christian Allen

18. Mother's Name (First, Middle, Maiden Surname)

Mary Holmes

19a. Informant's Name/Relationship (Type, Print)

Marita Douglas/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8511 Brae Brook Drive, Lanham, MD 20706

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)Program 7/12
Virginia State Anatomical 1996

Date

20c. Location - City or Town, State

Richmond, Virginia

21. Signature of Funeral Service Licensee

#M00690

22. Name and Address of Facility

Metropolitan Funeral Service, Inc.
5517 Vine Street, Alexandria, VA 2231023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. Artherosclerotic Cardiovascular Disease
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D17875

29d. Date signed (Month, Day, Year)

7/10/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. R. Nath, MD 14300 Gallant Fox Lane, Bowie, MD 20715

31. Date filed (Month, Day, Year)

JUL 15 1996

32. Registrar's Signature

Julia A. ...

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

96-3855-033

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEM: 28c, PER ME0 FILM G-741 State of Maryland / Department of Health and Mental Hygiene
11/27/96 t.t

96 23157

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DWAYNE

A.

WILLIAMS

2. Date of Death

Month
JULYDay
11Year
1996

3. Time of Death

2:05 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

BUDDY ATTICK PARK

4b. City, Town, or Location of Death

GREENBELT

4c. County of Death

PRINCE GEORGES

5. Social Security Number

212-98-2361

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

25

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
FEB. 2, 1971

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

MARYLAND PRINCE GEORGE'S

UPPER MARLBORO

☒ Yes ☐ No

10e. Street and Number

10 STATON DRIVE

10f. Zip Code

20774

10g. Citizen of What Country?

USA

11. Marital Status

XX

Never Married ☐ Married ☐☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 years

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

COUNSELOR

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

RONALD WILLIAMS

18. Mother's Name (First, Middle, Maiden Surname)

VIRGINIA STEPHENS

19a. Informant's Name/Relationship (Type, Print)

RONALD WILLIAMS / FATHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 STATON DR. UPPER MARLBORO, MD 20774

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FT. LINCOLN CEMETERY

Date

7-18-96

20c. Location - City or Town, State

BRENTWOOD, MD

21. Signature of Funeral Service Licensee

Suawana L. Baxton

22. Name and Address of Facility

Marshall's Funeral Home
4308 Suitland Rd. Suitland, Maryland 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Drowning
Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☒ Other (Specify)

LAKE

27. Manner of Death

☐ Natural☒ Accidental☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

7-8-96

28b. Time of Injury

1330 M

28c. Injury at Work?

☒ Yes ☐ No

28d. Describe how injury occurred

Subject fell out of boat

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

LAKE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Greenbelt Lake, Greenbelt, MD

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. H. Locke, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 12, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J. H. Locke, MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 15 1996

32. Registrar's Signature

John H. Locke, MD

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

96-4227-510
AM
UNK.96-170

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23158

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) TYRONE ALSTON		2. Date of Death Month JULY Day 29 Year 1996		3. Time of Death 22:01 P
	4a. Facility Name (If not institution, give street and number) 1058 BETHUNE RD. IN REAR		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NIA
Funeral Director	5. Social Security Number 213-64-5159	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 43 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) June 6, 1953		9. Birthplace (State or Foreign Country) md		
To Be Completed by Funeral Director	Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. State md	10b. County NIA	10c. City, Town or Location Balto		10f. Zip Code 21214
To Be Completed by Physician/Medical Examiner	10e. Street and Number 2202 N. Rosedale st		10g. Citizen of What Country? U.S.A		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
To Be Completed by Physician/Medical Examiner	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) NIA		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) factor worker		16b. Kind of Business/Industry LOCKE INSULATION		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Marvin N. Alston		18. Mother's Name (First, Middle, Maiden Surname) Martha Patterson		
	19a. Informant's Name/Relationship (Type, Print) Marlene Watson - Sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2401 N. Rolling Rd Balto, md 21214		
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem Pk		20c. Location - City or Town, State Arbutus, md
	21. Signature of Funeral Service Licensee W. E. Edmond		22. Name and Address of Facility Marion F. West 4300 Webster Ave		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wound of Head Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) FIELD		
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 7/29/96		28b. Time of Injury 2:15 PM
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject shot		
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street		28f. Location (Street and Number or Rural Route Number, City or Town, State) 1058 Bethune Baltimore, Md		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
State Registrar	29b. Signature and title of certifier Dennis J. Chute MD		29c. License number OCME		29d. Date signed (Month, Day, Year) JULY 30, 1996
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201				
State Registrar	31. Date filed (Month, Day, Year) AUG 06 1996		32. Registrar's Signature John Shuler-Randall		

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

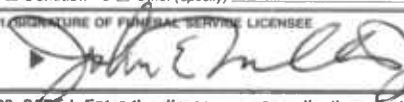

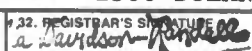
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) CATHERINE LORETTA ADAMS				2. DATE OF DEATH MONTH DAY YEAR July 31, 1996				3. TIME OF DEATH 9:30 A					
4. SOCIAL SECURITY NUMBER 217-26-0221		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Sept. 15, 1918		8. BIRTHPLACE (State or Foreign Country) Md.			
9a. FACILITY NAME (If not institution, give street and number) Mercy Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH N/A					
RESIDENCE OF DECEDENT													
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Dundalk				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 7935 St. Claire Lane				10f. ZIP CODE 21222				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 yrs College (1-4 or 5 +)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife				16b. KIND OF BUSINESS/INDUSTRY Home					
17. FATHER'S NAME (First, Middle, Last) George Elmer Mason						18. MOTHER'S NAME (First, Middle, Maiden Surname) Agnes Holter							
19a. INFORMANT'S NAME (Type/Print) Loretta Adams-Daughter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 57 Kinship Rd. Dundalk Md. 21222									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Baltimore Cem.				DATE 8-3		20c. LOCATION — City or Town, State Baltimore					
21. SIGNATURE OF FUNERAL SERVING LICENSEE 				22. NAME AND ADDRESS OF FACILITY Connolly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. COLON CANCER with LIVER METS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.										Approximate Interval Between Onset and Death 3 months			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER D25043		29d. DATE SIGNED (Month, Day, Year) 7/31/96					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD. TOWSON, MD 21204													
31. DATE FILED (Month, Day, Year) AUG 06 1996				32. REGISTRAR'S SIGNATURE 									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23160

ITEM#23a g738 8/14/96ag perDr.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Maytress Brokke</i>		2. Date of Death Month <i>Aug</i> Day <i>2</i> Year <i>1996</i>		3. Time of Death <i>0625 AM</i>					
	4a. Facility Name (If not institution, give street and number) <i>Lorien Nursing and Rehabilitation Ctr, Baltimore</i>		4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>Baltimore city</i>					
Funeral Director	5. Social Security Number <i>213-32-6903</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>61</i> Yrs.	8. Date of Birth (Month, Day, Year) <i>March 19, 1935</i>	9. Birthplace (State or Foreign Country) <i>Virginia</i>					
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <i>Md.</i>	10b. County <i>Baltimore</i>	10c. City, Town or Location <i>Dundalk</i>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	10e. Street and Number <i>3406 Loganview Dr.</i>		10f. Zip Code <i>21222</i>		10g. Citizen of What Country? <i>USA</i>					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10 yrs.</i> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Housewife</i>		16b. Kind of Business/Industry <i>Home</i>					
	17. Father's Name (First, Middle, Last) <i>Henry Morris</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Blanche Shiflett</i>							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Ruben Brokke Husband</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3406 Loganview Dr. Dundalk Md. 21222</i>							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Holly Hill</i>		20c. Location - City or Town, State <i>Baltimore</i>					
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <i>Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222</i>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a. <i>Renal failure</i> Due to (or as a consequence of):</td> <td rowspan="4"> Approximate Interval Between Onset and Death <i>1 year</i> <i>5 years</i> </td> </tr> <tr> <td>b. <i>HYPERTENSION</i> Due to (or as a consequence of):</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table>					Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <i>Renal failure</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <i>1 year</i> <i>5 years</i>	b. <i>HYPERTENSION</i> Due to (or as a consequence of):	c. Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <i>Renal failure</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <i>1 year</i> <i>5 years</i>								
	b. <i>HYPERTENSION</i> Due to (or as a consequence of):									
	c. Due to (or as a consequence of):									
	d. Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Gangrene right foot</i>										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <i>NA</i> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <i>NA</i>	28b. Time of Injury <i>NA</i> M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <i>NA</i>					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Dr. Kay L. MD</i>								
29c. License number <i>D41617</i>		29d. Date signed (Month, Day, Year) <i>Aug. 2, 1996</i>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Gary Kacow MD 10805 Hickory Ridge Rd Columbia, MD 21045</i>										
31. Date filed (Month, Day, Year) <i>AUG 06 1996</i>		32. Registrar's Signature <i>[Signature]</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23161

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Lennan Bowen				2. Date of Death Month Day Year Aug. 3, 1996				3. Time of Death 7:15 am					
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A					
Funeral Director	5. Social Security Number 218-36-0552		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 56 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) Nov. 21, 1939		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State Md.		10b. County Baltimore		10c. City, Town or Location Dundalk						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 3434 Cornwall Rd.				10f. Zip Code 21222				10g. Citizen of What Country? USA					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 yrs.				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Millwright				18b. Kind of Business/Industry Beth. Steel					
	17. Father's Name (First, Middle, Last) Robert Lee Bowen						18. Mother's Name (First, Middle, Maiden Surname) Mary Jones							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Jean Bowen Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3434 Cornwall Rd. Dundalk Md. 21222									
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cem				Date 8-7		20c. Location - City or Town, State Baltimore			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ARTERIO SCLEROTIC CARDIOVASCULAR DIS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. { Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last													
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CARCINOMA OF PROSTATE													
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown													
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)				28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred	
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
	29b. Signature and title of certifier 				29c. License number D11054				29d. Date signed (Month, Day, Year) 08/05/96					
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Larry G. Tilley 1012 North Point Rd. Dundalk Md. 21222													
31. Date filed (Month, Day, Year) AUG 06 1996														
32. Registrar's Signature 														

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

ITEM: 19a, PER F.H. FILM G-738 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

8/6/96 t.t

Certificate of Death

Reg. No.

96 23162

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SUSAN K. BRAFMANN

2. Date of Death

July 30 1996

3. Time of Death

3:15 pm

4a. Facility Name (If not institution, give street and number)

6617 WICKFIELD RD.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

215-01-4310

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

AUG. 3, 1908

9. Birthplace (State or Foreign Country)

FRANCE

Usual Residence of Decedent

10a. State
MARYLAND

10b. County
BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6617 WICKFIELD ROAD

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

CHARLES

KAHN

18. Mother's Name (First, Middle, Maiden Surname)

MINNA

NUSBAUM

19a. Informant's Name/Relationship (Type, Print)

MR. HARRY HARRY

BRAFMANN

(SON) 7925 LONG MEADOW ROAD BALTIMORE, MD 21208

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BETH EL MEMORIAL PARK - 7-31-1996- RANDALLSTOWN, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

John A. Lewis

22. Name and Address of Facility

Sol Levinson & Bros., Inc.
8900 Reisterstown Road Pikesville, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. PNEUMONIA

Approximate Interval Between Onset and Death

2 DAYS

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMER'S DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

N/A

28b. Time of Injury

N/A M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

M.P. Daly

29c. License number

D 30433

29d. Date signed (Month, Day, Year)

7/30/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

M.P. DALY, M.D. 2200 KERNAN DRIVE BALTIMORE MD 21207

31. Date filed (Month, Day, Year)

AUG 06 1996

32. Registrar's Signature

John A. Lewis

Baltimore, Maryland 21215-0020

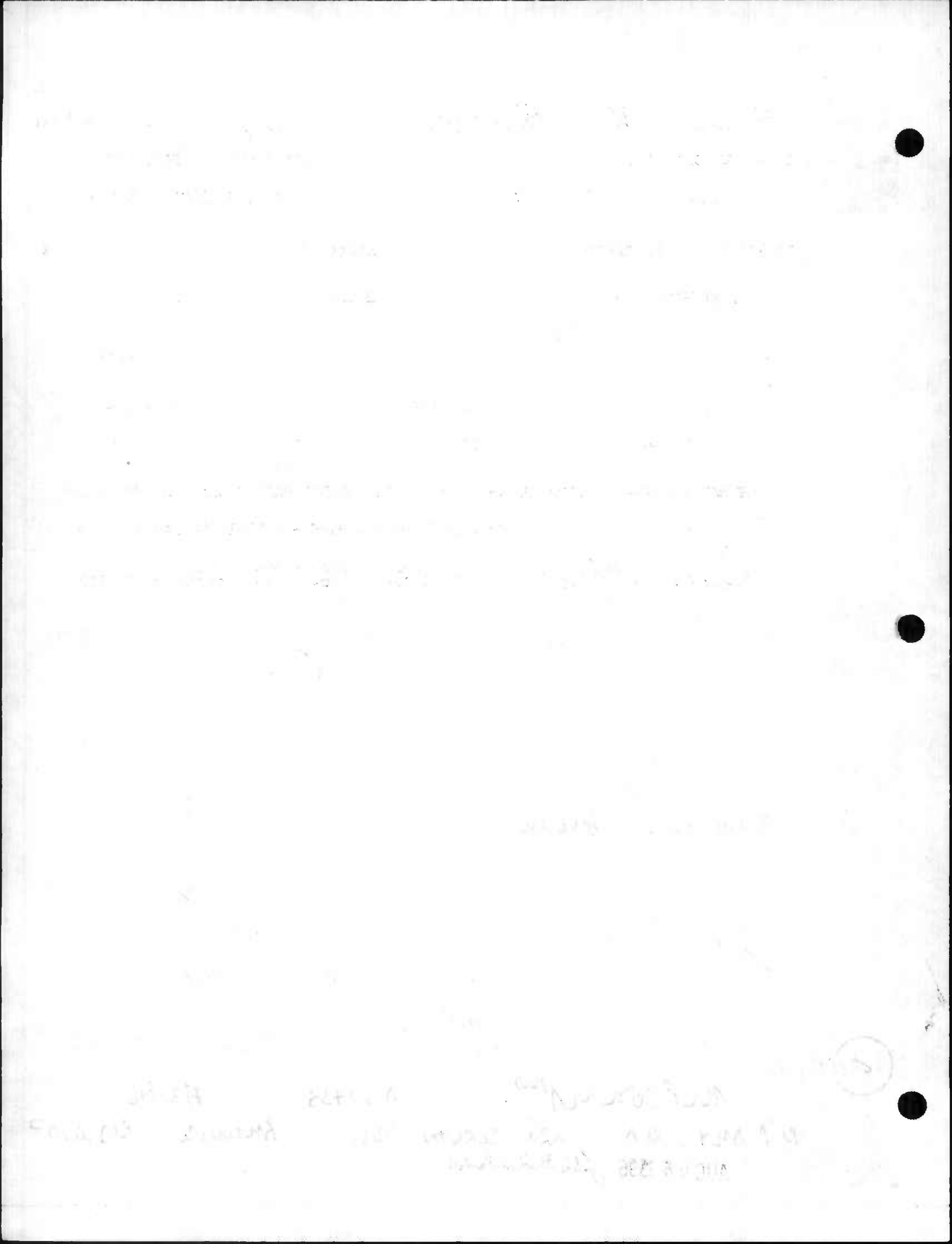
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23163

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bella R Baron		2. Date of Death Month July Day 30 Year 96		3. Time of Death 1338
	4a. Facility Name (If not Institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO
Funeral Director	5. Social Security Number 218-32-6631	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) 12-06-35		9. Birthplace (State or Foreign Country) MARYLAND		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State VA.		10b. County
	10c. City, Town or Location GREENBACKVILLE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 3536 CAPTAINS CORRIDOR		10f. Zip Code 23356		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16. Kind of Business/Industry OWN HOME
	17. Father's Name (First, Middle, Last) ISADOR AUERHAN		18. Mother's Name (First, Middle, Maiden Surname) EDITH KOVELER		
	19a. Informant's Name/Relationship (Type, Print) MR. STANLEY BARON (HUSBAND)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3536 CAPTAINS CORRIDOR GREENBACKVILLE, VA 23356		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MOSES MONTEFIORE		20c. Location - City or Town, State 8-1-1996 BALTIMORE, MD
	21. Signature of Funeral Service Licensee John G. Bulkeley		22. Name and Address of Facility Sol Levinson & Bros., Inc. 8900 Reisterstown Road Pikesville, MD 21208		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Multiple Sclerosis Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Approximate Interval Between Onset and Death		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Multiple Sclerosis		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier John G. Bulkeley D.M.E.		29c. License number 003599		29d. Date signed (Month, Day, Year) 7-30-96	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John T. Bulkeley, M.D., 108 Pine Bluff Rd., Salisbury, Md.					
31. Date filed (Month, Day, Year) AUG 06 1996		32. Registrar's Signature John T. Bulkeley			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To this Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

This Hospital or Attending Physician: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Page 10

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23164

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ARLENE FRANCES BROWN				2. Date of Death Month Day Year AUGUST 4, 1996		3. Time of Death 3:00pm		
	4a. Facility Name (If not institution, give street and number) 1541 Florida Avenue				4b. City, Town, or Location of Death Severn		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 212-58-8156		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 45 Yrs.		8. Date of Birth (Month, Day, Year) Mar. 22, 1951		
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Severn		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1541 Florida Avenue		10f. Zip Code 21144		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse		16b. Kind of Business/Industry Medical					
17. Father's Name (First, Middle, Last) Arnold Donachy				18. Mother's Name (First, Middle, Maiden Surname) Doris Noble					
19a. Informant's Name/Relationship (Type, Print) Jack Eugene Brown Sr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1541 Florida Avenue, Severn, MD 21144					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem. 8/7		Date Crownsville, MD		20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HARDESTY FUNERAL HOME P.A. 851 ANNAPOLIS RD. GAMBRILLS MARYLAND 21041					
23a. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Glioblastoma multiforme Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 8 mos.	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		28. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D31557		29d. Date signed (Month, Day, Year) August 5, 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Russell R. DeLuca, M.D. 1600 S. Crain Highway, 6th Floor, Baltimore, MD 21061		31. Date filed (Month, Day, Year) AUG 06 1996		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

96 23165

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELIZABETH CHESTER BURHORST				2. Date of Death Month Day Year JULY 30, 1996		3. Time of Death 5:55 P.M.												
	4a. Facility Name (If not institution, give street and number) GENESIS ELDER CARE				4b. City, Town, or Location of Death BALTIMORE COUNTY		4c. County of Death BALTIMORE												
Funeral Director	5. Social Security Number 215-24-6376	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCTOBER 18, 1904		9. Birthplace (State or Foreign Country) BALTIMORE, MARYLAND											
	Usual Residence of Decedent																		
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County BALTIMORE CITY	10c. City, Town or Location BALTIMORE			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No													
	10e. Street and Number 2900 BERWICK AVENUE			10f. Zip Code 21234		10g. Citizen of What Country? U.S.A.													
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE												
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6		College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FACTORY WORKER		16b. Kind of Business/Industry CONTINENTAL CAN COMPANY												
	17. Father's Name (First, Middle, Last) UNKNOWN				18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN														
	19a. Informant's Name/Relationship (Type, Print) JOAN BEATTY (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2900 BERWICK AVENUE BALTIMORE, MARYLAND 21234														
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MORELAND MEMORIAL PARK		Date AUGUST 3, 1996		20c. Location - City or Town, State BALTIMORE, MARYLAND												
	21. Signature of Funeral Service Licensee <i>Boether</i>				22. Name and Address of Facility LASSAHN FUNERAL HOME, INC. 7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625														
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <i>Sepsis</i></td> <td>Approximate Interval Between Onset and Death <i>< 1 wk</i></td> </tr> <tr> <td>b. <i>Dehydration</i></td> <td><i>< 1 mo</i></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <i>Sepsis</i>	Approximate Interval Between Onset and Death <i>< 1 wk</i>	b. <i>Dehydration</i>	<i>< 1 mo</i>	c.		d.			
Immediate Cause (Final disease or condition resulting in death)	a. <i>Sepsis</i>	Approximate Interval Between Onset and Death <i>< 1 wk</i>																	
	b. <i>Dehydration</i>	<i>< 1 mo</i>																	
	c.																		
	d.																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - Ascites - Abdominal - Dementia - Hyperbilirubinemia																			
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined											
28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred											
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D41901				29d. Date signed (Month, Day, Year) 7/31/96			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Zia K-Mirza MD 3007 E Northem																			
31. Date filed (Month, Day, Year) AUG 06 1996				32. Registrar's Signature <i>[Signature]</i>															

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

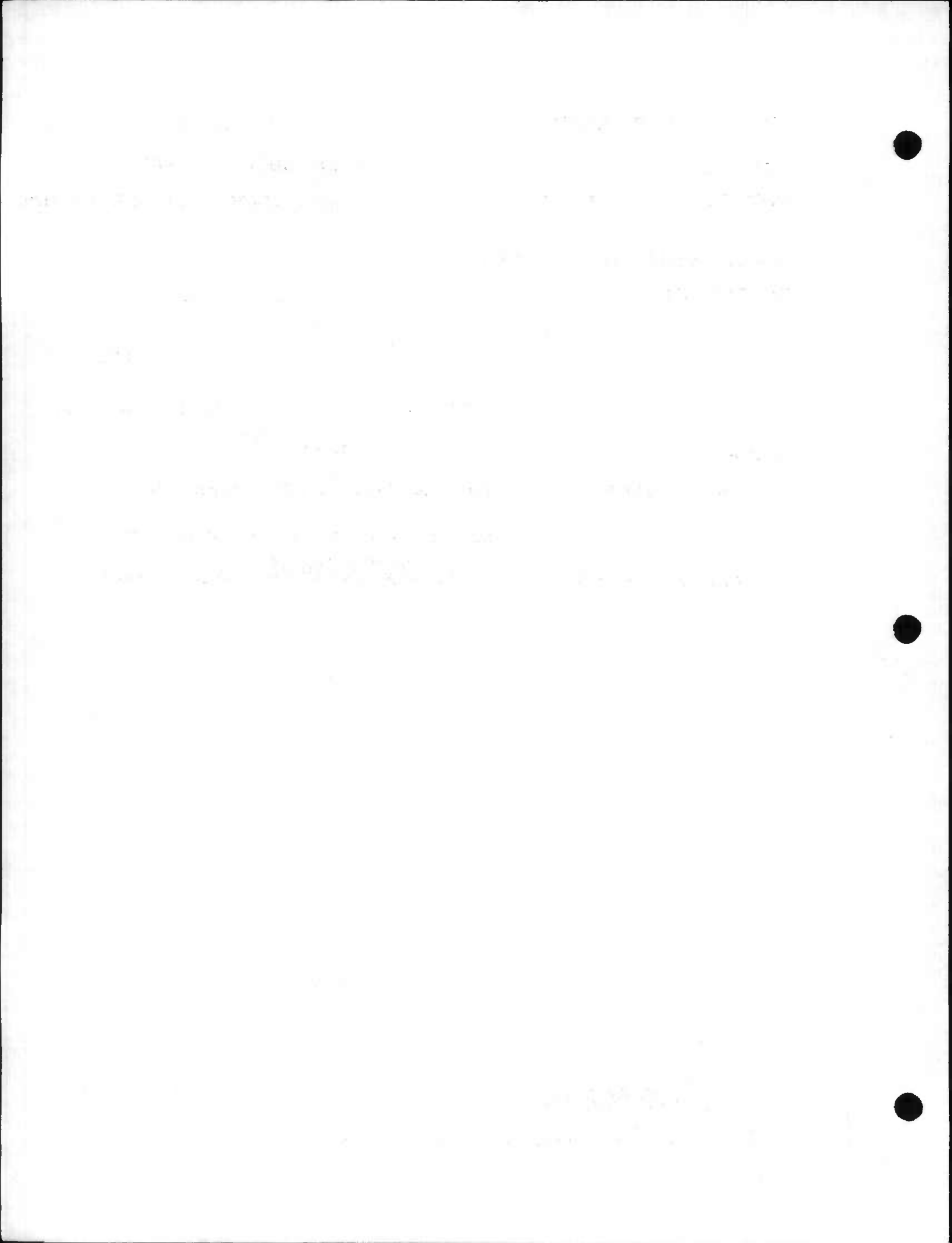
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23166

Item 6, Film 738, 8/7/96, 1t

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Florence Barrett

2. Date of Death

August 2, 1996

3. Time of Death

11:12 AM

4a. Facility Name (If not institution, give street and number)

UNIVERSITY HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

Funeral
Director

5. Social Security Number

217-58-2202

6. Sex

154 M 254 F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

4/4/1922

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

26 CHESTER CIRCLE

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
NONE

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

EUGENE ARNOLD JARBOE

18. Mother's Name (First, Middle, Maiden Surname)

MARION JEANETTE COLE

19a. Informant's Name/Relationship (Type, Print)

MILTON EMORY BARRETT (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

26 CHESTER CIRCLE, GLEN BURNIE, MD 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GLEN HAVEN MEMORIAL PARK

Date

8/5/96

20c. Location - City or Town, State

GLEN BURNIE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SINGLETON FUNERAL HOME

1 SECOND AVE. S.W., GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

PO 8655

29d. Date signed (Month, Day, Year)

August 2, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JONATHAN FISH MD 22 S GREENE ST BALTIMORE, MD 21201

31. Date filed (Month, Day, Year)

AUG 06 1996

32. Registrar's Signature

John A. Russell

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23167

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>TRESLA BUSHROD</u>				2. Date of Death Month <u>07</u> Day <u>31</u> Year <u>96</u>		3. Time of Death <u>0210</u>	
	4a. Facility Name (If not institution, give street and number) <u>UNIVERSITY OF MARYLAND MEDICAL SYSTEM</u>				4b. City, Town, or Location of Death <u>BALTIMORE</u>		4c. County of Death <u>BALTIMORE CITY</u>	
Funeral Director	5. Social Security Number <u>215-92-9030</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>30</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>2/7/1966</u>	
	9. Birthplace (State or Foreign Country) <u>MARYLAND</u>		10a. State <u>MARYLAND</u>		10b. County <u>BALTIMORE, CITY</u>		10c. City, Town or Location <u>BALTIMORE</u>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <u>1415 WARD STREET</u>		10f. Zip Code <u>21230</u>		10g. Citizen of What Country? <u>U.S.A.</u>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>BLACK</u>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>0</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>DISTRIBUTOR</u>		16b. Kind of Business/Industry <u>ADVERTISING CO.</u>			
	17. Father's Name (First, Middle, Last) <u>LAWRENCE BUSHROD</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>ISABELLE BUSHROD</u>			
	19a. Informant's Name/Relationship (Type, Print) <u>LAWRENCE BUSHROD (FATHER)</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1415 WARD STREET BALTIMORE, MARYLAND 21230</u>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>MOUNT ZION CEMETERY 8/3/96</u>		20c. Location - City or Town, State <u>LANSDOWNE, MARYLAND</u>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <u>ESTEP BROTHERS FUNERAL HOME PA. 1300 EUTAW PLACE BALTIMORE, MARYLAND 21217</u>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>SHOCK</u> Due to (or as a consequence of): b. <u>HEMORRHAGE</u> Due to (or as a consequence of): c. <u>CESARIAN SECTION</u> Due to (or as a consequence of): d. <u>CHORIOAMNIONITIS</u> Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Approximate Interval Between Onset and Death <u>24 HRS</u> <u>36 HRS</u> <u>40 HRS</u> <u>2 DAYS</u>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier  MD				29c. License number <u>A04076435603078</u>		29d. Date signed (Month, Day, Year) <u>07/31/96</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>DEBORAH GLASSMAN 22 S. GREENE ST. BALTIMORE, MD 21201</u>								
31. Date filed (Month, Day, Year) <u>AUG 06 1996</u>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23168

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THELMA CRAIG				2. Date of Death Month AUGUST Day 5 Year 1996		3. Time of Death 11:40 pm																																
	4a. Facility Name (If not Institution, give street and number) North West Hospital Center				4b. City, Town, or Location of Death Randallstown		4c. County of Death Baltimore																																
Funeral Director	5. Social Security Number 213-38-8960		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 59 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 31, 1936																																
	9. Birthplace (State or Foreign Country) West Virginia		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Randallstown																																
To Be Completed by Funeral Director	10d. Inside City Limits 1 Yes 2 No		10e. Street and Number 10116 Liberty Road		10f. Zip Code 21133		10g. Citizen of What Country? United States																																
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: Caucasian																																
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5th.		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home																																		
	17. Father's Name (First, Middle, Last) John Queen				18. Mother's Name (First, Middle, Maiden Surname) Naomi Shackelford																																		
	19a. Informant's Name/Relationship (Type, Print) Paul C. Craig				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10116 Liberty Rd Randallstown, MD 21133																																		
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery August 9, 1996		20c. Location - City or Town, State Woodlawn, Maryland																																		
	21. Signature of Funeral Service Licensee Joseph J. W. Kellner				22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Rd Randallstown, MD 21133-4784																																		
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																						
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>HYPERTENSION</td> <td>1 DAY</td> </tr> <tr> <td>b.</td> <td>DIGITALIS TOXICITY</td> <td>1 DAY</td> </tr> <tr> <td>c.</td> <td>SEIZURES POST CARDIAC ARREST</td> <td>2 YEARS</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a.	HYPERTENSION	1 DAY	b.	DIGITALIS TOXICITY	1 DAY	c.	SEIZURES POST CARDIAC ARREST	2 YEARS	d.																				
	Immediate Cause (Final disease or condition resulting in death)	a.	HYPERTENSION	1 DAY																																			
b.		DIGITALIS TOXICITY	1 DAY																																				
c.		SEIZURES POST CARDIAC ARREST	2 YEARS																																				
d.																																							
<table border="1"> <tr> <td colspan="4">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</td> <td colspan="4">23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown</td> </tr> <tr> <td colspan="4">DIABETES MELLITUS</td> <td colspan="4"></td> </tr> <tr> <td colspan="4">CORONARY ARTERY DISEASE</td> <td colspan="4">24a. Was an autopsy performed? 1 Yes 2 No</td> </tr> <tr> <td colspan="4">CONGESTIVE HEART FAILURE</td> <td colspan="4">24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No</td> </tr> </table>								Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				DIABETES MELLITUS								CORONARY ARTERY DISEASE				24a. Was an autopsy performed? 1 Yes 2 No				CONGESTIVE HEART FAILURE				24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown																																			
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CORONARY ARTERY DISEASE				24a. Was an autopsy performed? 1 Yes 2 No																																			
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25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)																																					
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No																																	
		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																																	
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier MD		29c. License number BG 4439128		29d. Date signed (Month, Day, Year) AUGUST 5 1996																																	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS GEORGE, NORTHWEST HOSPITAL CTR. 5401 OLD COURT ROAD RANDALLSTOWN MD 21133																																							
31. Date filed (Month, Day, Year) AUG 06 1996		32. Registrar's Signature John D. ...																																					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

96 23169

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WARDLELL F. CLARK				2. DATE OF DEATH MONTH 8 DAY 3 YEAR 96		3. TIME OF DEATH 2207 P.M.	
4. SOCIAL SECURITY NUMBER 216-20-9341		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5-22-1926	
9a. FACILITY NAME (If not institution, give street and number) Bon Secour Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH NA	
10a. STATE Md				10b. COUNTY NA		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 716 Washington Place			
10f. ZIP CODE 21202				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) NA		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk		16b. KIND OF BUSINESS/INDUSTRY Coast Guard			
17. FATHER'S NAME (First, Middle, Last) John T. Clark, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Charlotta Clayton			
19a. INFORMANT'S NAME (Type/Print) Wilhelmina Curley - Sister				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 N. Hilton Street Baltimore			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet		DATE 8-9-96		20c. LOCATION — City or Town, State Owings Mills, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bladys Warner				22. NAME AND ADDRESS OF FACILITY March F.H. West 4300 Wabash Avenue Baltimore			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ACUTE MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PNEUMONIC CARCINOMA DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death 30' 10 YRS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER John Shavers				29c. LICENSE NUMBER 077838		29d. DATE SIGNED (Month, Day, Year) 8/5/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Shavers 578 Camp Meade Road Linthicum, Md 21090							
31. DATE FILED (Month, Day, Year) AUG 06 1996				32. REGISTRAR'S SIGNATURE John Shavers-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 23170

DMMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23171

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT

CHANEY

2. Date of Death

Month Day Year

August 04 1996

3. Time of Death

5:40 AM

4a. Facility Name (If not institution, give street and number)

STELLA MARIS - MERCY HOSP

4b. City, Town, or Location of Death

BALTO

4c. County of Death

NA

Funeral
Director

5. Social Security Number

218-28-0709

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

3-23-23

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

BALTO

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3764 DOLFELD AVE

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

NA

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CABINET MAKER

16b. Kind of Business/Industry

Wallbrook Mill & Lumber

17. Father's Name (First, Middle, Last)

CHARLIE M. CHANEY

18. Mother's Name (First, Middle, Maiden Surname)

ADA EDMONDS

19a. Informant's Name/Relationship (Type, Print)

Dorothy CHANEY - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3764 DOLFELD AVE BALTO, MD 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest vet

Date

8/4/96

20c. Location - City or Town, State

Owning mills, md

21. Signature of Funeral Service Licensee

Sharon Stokes

22. Name and Address of Facility

March A H - west
4300 Wabash Ave

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC COLON CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 yr.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. J. J. J. J.

29c. License number

D40480

29d. Date signed (Month, Day, Year)

August 5, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FERNANDO J. FERRAO, MD

5810 BELAIR RD

BALTO, MD 21206

31. Date filed (Month, Day, Year)

AUG 06 1996

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23172

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HAROLD

COOK

2. Date of Death

Month Day Year
August 3, 1996

3. Time of Death

9:18 pm

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

220-10-4522

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 3, 1913

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

229 Baltimore Avenue-Apt. 209

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Grounds Keeper

16b. Kind of Business/Industry

Cumberland Country
Club

17. Father's Name (First, Middle, Last)

Charles Cook

18. Mother's Name (First, Middle, Maiden Surname)

Laura Boyer

19a. Informant's Name/Relationship (Type, Print)

Martha Cook/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

229 Baltimore Avenue-Apt. 209-Cumberland, MD. 21502

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Dir.

22. Name and Address of Facility

State Anatomy Board-655 W. Baltimore Street
Baltimore, Maryland 21201-155923a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Acute MI-Inferior

Due to (or as a consequence of):

24 hours

b. Coronary Artery Disease

Due to (or as a consequence of):

10 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CA Lung-Small Cell, Metastatic Lesions To Brain

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 18769

29d. Date signed (Month, Day, Year)

August 3, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. James Raver, Memorial Hospital, Cumberland, MD 21502

State
Registrar

31. Date filed (Month, Day, Year)

AUG 06 1996

32. Registrar's Signature

Julia Davidson

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at office.

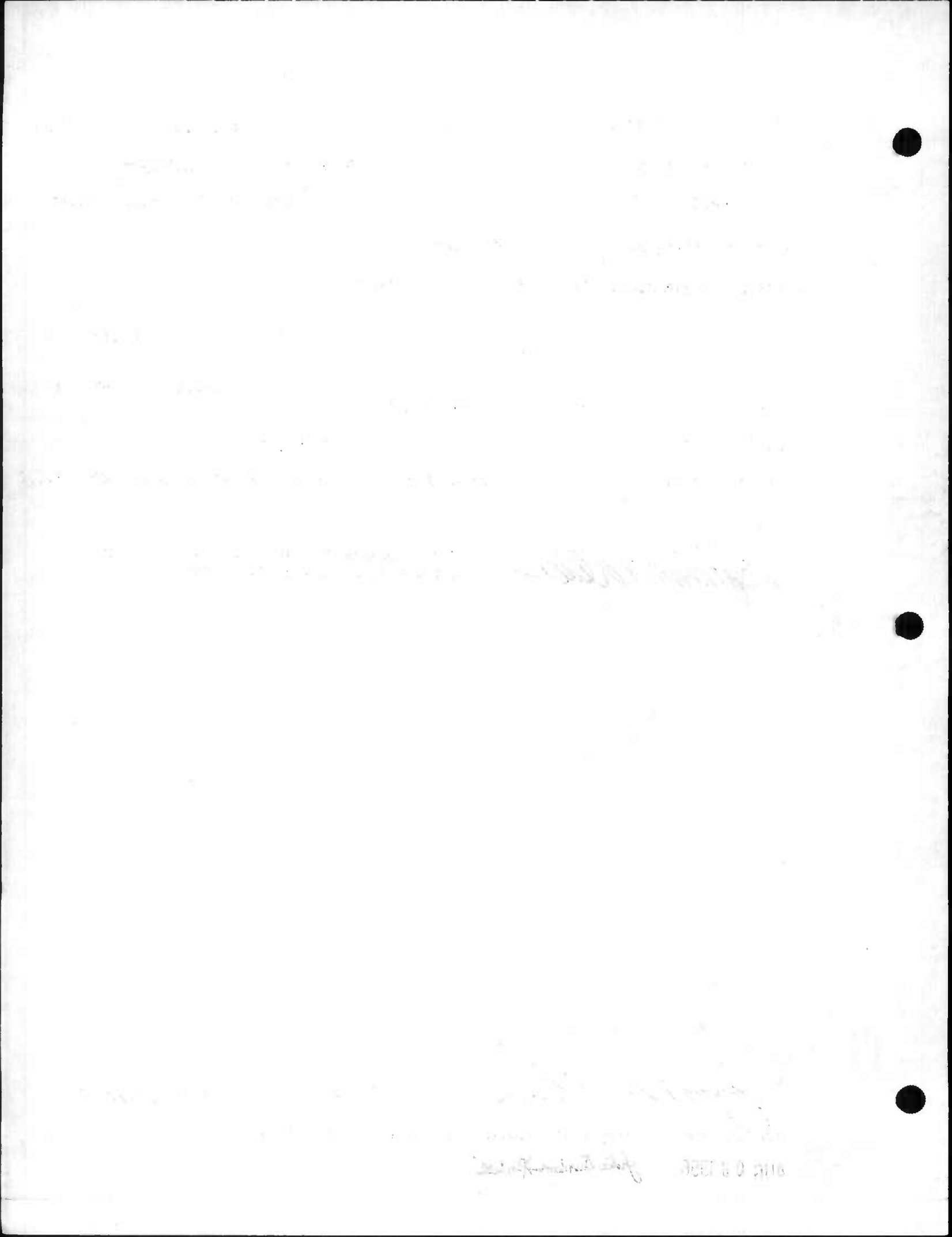
Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23173

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bernard P Cunningham				2. Date of Death Month August 2, Day 1996 Year				3. Time of Death 4:30 p.m.		
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Tacoma Park				4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 217-16-0079		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 16, 1923		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent				10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Glen Burnie		
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 217 Main Ave. S.W.		10f. Zip Code 21061		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1944- If Yes, Give Year or Dates: 1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Inspector				16b. Kind of Business/Industry Road Construction		
	17. Father's Name (First, Middle, Last) Percy Cunningham				18. Mother's Name (First, Middle, Maiden Surname) Anna						
	19a. Informant's Name/Relationship (Type, Print) Vernon Woody				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 217 Main Ave. S.W. Glen Burnie, MD 21061						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Mem. Pk. Aug. 6, 1996		Date		20c. Location - City or Town, State Glen Burnie, MD				
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Hwy. S.E. Glen Burnie, MD 21061						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Cardiogenic Shock</u> Due to (or as a consequence of): b. <u>Alcoholic Cardiomyopathy</u> Due to (or as a consequence of): c. <u>Chronic Alcoholism</u> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 10 days 5 years 10 years						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Staphylococcus Septicemia, Renal Failure;</u> <u>Coronary Artery Disease</u>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number D 22755		29d. Date signed (Month, Day, Year) August 2 1996	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRISTINE DE LIMA 7350 VAN DUSEN RD # 260 LAUREL MD 20707											
31. Date filed (Month, Day, Year) AUG 06 1996				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23174

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THOMAS COVER III		2. Date of Death Month Day Year August 5, 1996		3. Time of Death 9:15 a.m.
	4a. Facility Name (If not institution, give street and number) Blakehurst Health Center		4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 213-05-7416	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Jan. 4, 1906		9. Birthplace (State or Foreign Country) Virginia		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State MD		10b. County Baltimore
	10c. City, Town or Location Towson		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number Blakehurst #301, 1055 Joppa RD		10f. Zip Code 21204		10g. Citizen of What Country? U.S.A
	11. Marital Status 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) President/Laundry & Drycleaning		16b. Kind of Business/Industry Laundry/Drycleaning		
	17. Father's Name (First, Middle, Last) Loring A. Cover, Sr.		18. Mother's Name (First, Middle, Maiden Surname) Grace Stayman		
	19a. Informant's Name/Relationship (Type, Print) Anne C. Cover, wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blakehurst #301, 1055 Joppa Rd, Towson, MD 21204		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory 8-6		20c. Location - City or Town, State Baltimore, MD
	21. Signature of Funeral Service Licensee Henry W. Jenkins & Sons Co.		22. Name and Address of Facility 4905 York Rd., Baltimore, MD 21212		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic cancer, unknown primary Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and Title of certifier Susan M. Molinaro, MD		29c. License number D37144		29d. Date signed (Month, Day, Year) Aug. 5, 1996	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Susan M. Molinaro, MD, 10755 Falls Rd, Suite 200, Lutherville, MD 21093					
31. Date filed (Month, Day, Year) AUG 06 1996		32. Registrar's Signature Davidson-Rendell			

Certificate of Death

Reg. No.

DMMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23176

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KENNETH LEWIS CARMICHAEL JR.			2. Date of Death Month: AUGUST Day: 01 Year: 1996		3. Time of Death 2:45 A		
	4e. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL			4b. City, Town, or Location of Death BALTIMORE		4c. County of Death n/a		
Funeral Director	5. Social Security Number unknown		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 18 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) NOV. 24, 1977	
	9. Birthplace (State or Foreign Country) BALTIMORE, MD							
To Be Completed by Funeral Director	Usual Residence of Decedent			10a. State MD		10b. County n/a		
	10c. City, Town or Location BALTIMORE			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	10e. Street and Number 3212 CLIFTMONT AVENUE			10f. Zip Code 21213		10g. Citizen of What Country? UNITED STATES		
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 th College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STUDENT		16b. Kind of Business/Industry unemployed			
	17. Father's Name (First, Middle, Last) KENNETH L. CARMICHAEL SR.			18. Mother's Name (First, Middle, Maiden Surname) DENISE CRUMP				
	19a. Informant's Name/Relationship (Type, Print) DENISE CRUMP			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3212 CLIFTMONT AVENUE, BALTIMORE, MD 21213				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) VOSHALL MEMORIAL GARDENS		20c. Location - City or Town, State 8-7 DUNDALK, MD			
	21. Signature of Funeral Service Licensee L. Valencia Holland			22. Name and Address of Facility WM. C. MARCHFH.-1101 E. NORTH AVENUE				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wound of Neck Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 8-1-96		28b. Time of Injury 0218 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET		28d. Describe how injury occurred Subject shot						
28f. Location (Street and Number or Rural Route Number, City or Town, State) 1205 Bk. Montford Ave								
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier J. Aaron Locke, MD				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) AUGUST 01, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) AUG 06 1996								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23177

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LESLIE A. DAVID

2. Date of Death

Month Day Year
AUG. 2, 1996

3. Time of Death

2143 hrs

4a. Facility Name (If not institution, give street and number)

9007 ORCHARD VIEW AVE.

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

214-64-2156

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

42 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
SEPT. 27, 1953

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

RANDALLSTOWN

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9007 ORCHARD VIEW AVENUE

10f. Zip Code

21133

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
7

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CLERK

16b. Kind of Business/Industry

ALARM SYSTEMS

17. Father's Name (First, Middle, Last)

ERIC DAVID

18. Mother's Name (First, Middle, Maiden Surname)

ROSE LEVINSON

19a. Informant's Name/Relationship (Type, Print)

ANDREW DAVID (BROTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3971 VIEW TOP ROAD, ELLICOTT CITY, MD 21042

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BNAI ISRAEL

Date

8-4-96

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

Scott M. Cottle

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Self-inflicted shot gun wound of head

IMMEDIATE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Chronic depression

2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

08-02-96

28b. Time of Injury

2143 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Self-inflicted

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State)

9007 ORCHARD VIEW AVE

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. Crossan O'Donovan, M.D.

29c. License number

D07632

29d. Date signed (Month, Day, Year)

AUGUST 2, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J. CROSSAN O'DONOVAN, M.D., 3412 DUNDALK AVE., BALTO MD 21222

31. Date filed (Month, Day, Year)

AUG 06 1996

State
Registrar

Baltimore, Maryland 21215-0020

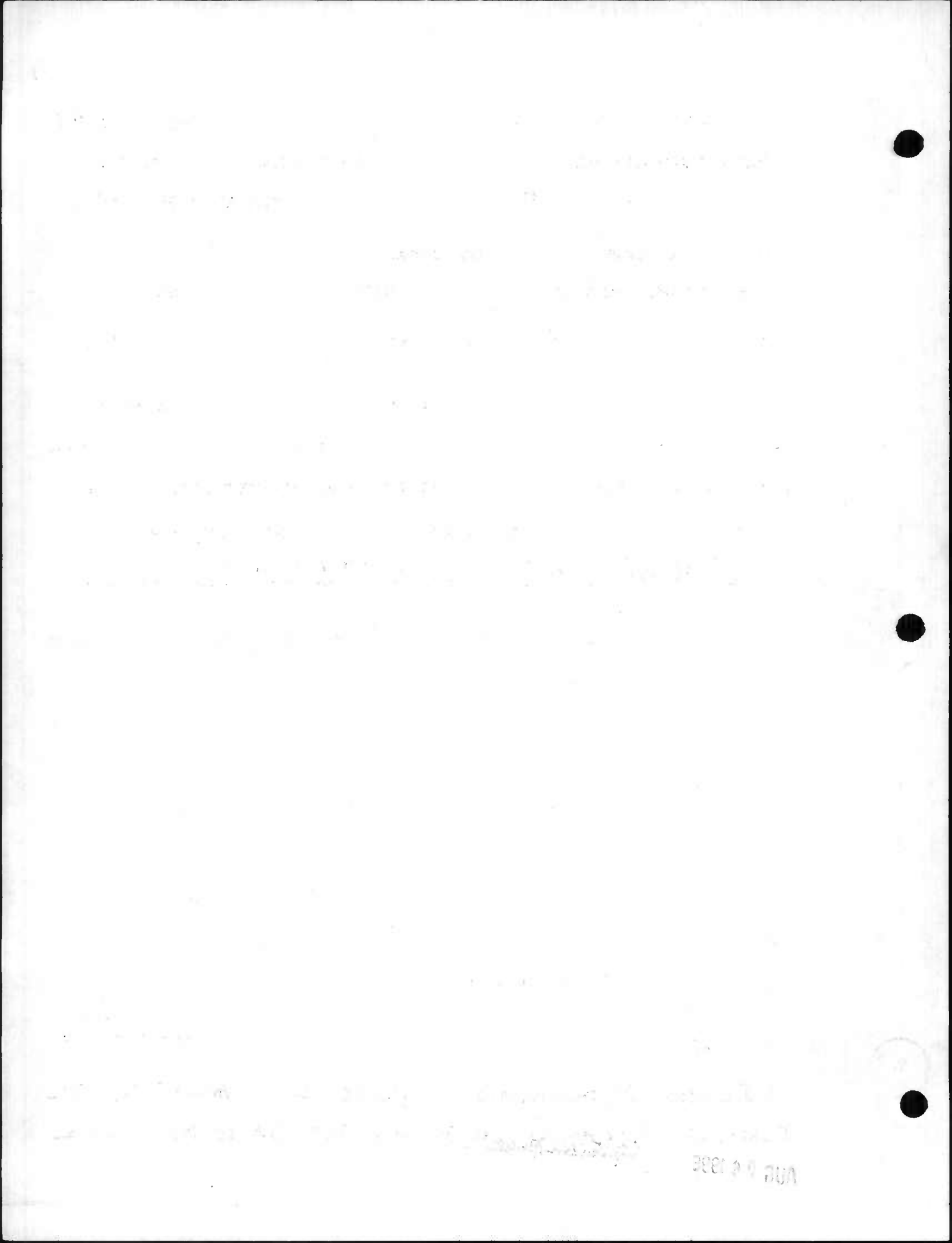
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23178

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES M. DUNCAN

2. Date of Death

Month Day Year
AUG. 02, 1996

3. Time of Death

1225 PM

4a. Facility Name (If not institution, give street and number)

ST. AGNES HOSPITAL E.R.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

202-34-3270

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

51

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

11-02-1944

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

PA

10b. County

CHESTER

10c. City, Town or Location

COATESVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

P.O. BOX 355, RD 3, HIGHLAND TWP

10f. Zip Code

19320

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:
WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SALES

16b. Kind of Business/Industry

REAL ESTATE

17. Father's Name (First, Middle, Last)

JOHN

DUNCAN

18. Mother's Name (First, Middle, Maiden Surname)

ROSE

Mc CLELLAN

19a. Informant's Name/Relationship (Type, Print)

MRS. CHRISTINE M. DUNCAN (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 355 RD3, COATESVILLE, PA 19320

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. MALACHI CEMETERY

Date

8/10/96 LONDONDERRY TOWNSHIP, PA.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SINGLETON FUNERAL HOME
1 SECOND AVE. S.W., GLEN BURNIE, MARYLAND 21061

23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Hypertensive Arteriosclerotic Cardiovascular Disease*
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28e. Date of Injury (Month, Day Year)

28f. Time of Injury

28g. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

AUG. 3, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

THEODORE M. KING

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 06 1996

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ITEM: 1. PER F.H. FILM G-738
8/6/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23179

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) FREDA EDELSON		2. Date of Death Month Aug Day 2 Year 1996		3. Time of Death 11:30 AM	
4a. Facility Name (If not institution, give street and number) LEVINDALE		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
5. Social Security Number 214-46-8046		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.	
8. Date of Birth (Month, Day, Year) SEPT. 17, 1904		9. Birthplace (State or Foreign Country) RUSSIA			
10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2500 W. BELVEDERE AVE., APT. 1106		10f. Zip Code 21215	
10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE		16b. Kind of Business/Industry OWN HOME		17. Father's Name (First, Middle, Last) MAX GERBER	
18. Mother's Name (First, Middle, Maiden Surname) ESTHER UNKNOWN		19a. Informant's Name/Relationship (Type, Print) MRS. HARRIET PLEET (DAUGHTER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 CANDLEMAKER CT., APT. 206 BALTIMORE, MD 21208	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HEBREW YOUNG MENS		20c. Location - City or Town, State 8-4-1996 BALTIMORE, MD	
21. Signature of Funeral Service Licensed <i>[Signature]</i>		22. Name and Address of Facility Sol Levinson & Bros., Inc. 8900 Reisterstown Road Pikesville, MD 21208		23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Colon Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i> MD		29c. License number D23767	
29d. Date signed (Month, Day, Year) August 2, 1996		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEBRA S WERTHEIMER MD 2434 W. Belvedere Ave, Balto, Md 21205		31. Data filed (Month, Day, Year) AUG 06 1996	
32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

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3

State
Registrar

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, the interpretation of the results, and the conclusions drawn from the study.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the theoretical and practical significance of the findings, and the limitations of the study.

5. The fifth part of the report is a conclusion and a summary of the main findings of the study. It includes a discussion of the overall results and the recommendations for further research.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23180

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Ethel M. Feild</i>				2. Date of Death Month <i>8</i> Day <i>2</i> Year <i>96</i>		3. Time of Death <i>2:50 P.</i>	
	4a. Facility Name (If not institution, give street and number) GILCHRIST CENTER				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 215-42-5487		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 12-02-1910	9. Birthplace (State or Foreign Country) NORTH CAROLINA
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 1 OAK COURT				10f. Zip Code 21218		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 YRS.		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SCHOOL TEACHER			16b. Kind of Business/Industry EDUCATION		
	17. Father's Name (First, Middle, Last) HOLDEN MCKEEL				18. Mother's Name (First, Middle, Maiden Surname) MAUDE MOORE			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) ROBERT FEILD				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 523 ALLEGHANY AVE. TOWSON, MD. 21204.			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) DRUID RIDGE		Date 8-5-96		20c. Location - City or Town, State PIKESVILLE, MD.	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212.			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Inevitable</i> Due to (or as a consequence of): <i>Adenocarcinoma lung, left</i> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death 3 WEEKS 76m.							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>Nursing Home</i>					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D11575		29d. Date signed (Month, Day, Year) 8/3/96		
30. Name and address of person who completed cause of death (from 23a) (Type, Print) 600 North Avenue, Baltimore, 21210								
31. Date filed (Month, Day, Year) AUG 06 1996				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

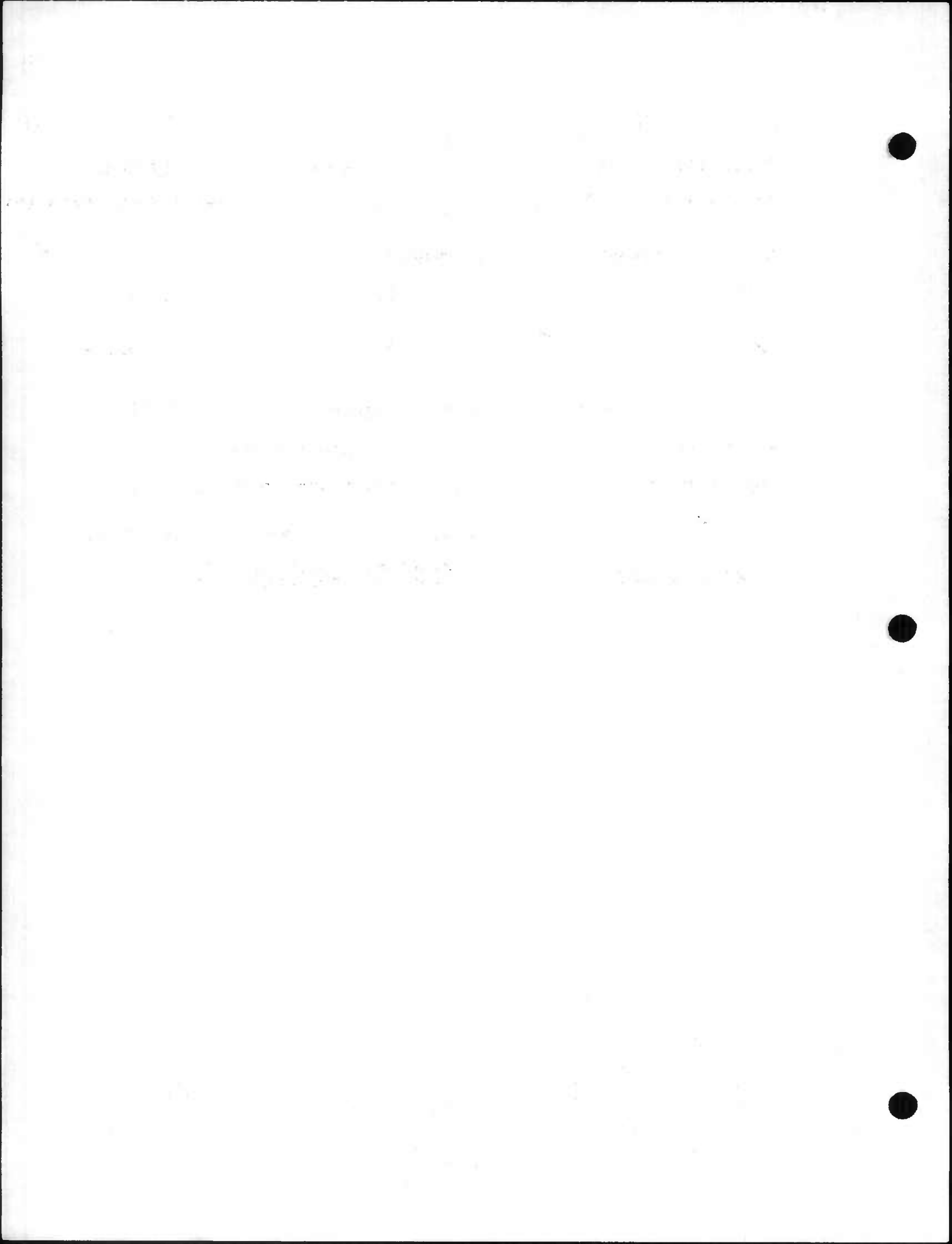
Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23181

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VERA FOHS				2. Date of Death Month Day Year AUGUST 4 1996				3. Time of Death 3:45 A.M.	
	4a. Facility Name (If not institution, give street and number) MERIDIAN PERRY PARKWAY				4b. City, Town, or Location of Death PARKVILLE				4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 218-46-1338		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) 1/18/12		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent									
10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location RIGELEIGH				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 1901 WILDWOOD AVENUE				10f. Zip Code 21234				10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5th GRADE				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER				16b. Kind of Business/Industry OWN HOME		
17. Father's Name (First, Middle, Last) WILLIAM THOMAS KENNEY						18. Mother's Name (First, Middle, Maiden Surname) IDA MAY MITCHELL				
19a. Informant's Name/Relationship (Type, Print) LOLA D. BANNASCH DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1901 WILDWOOD AVE. BALTIMORE, MD 21234						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE CEMETERY		20c. Date 8/7/96		20d. Location - City or Town, State BALTIMORE, MD		
21. Signature of Funeral Service Licensee				22. Name and Address of Facility JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
<p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <i>Acute myocardial infarction</i></p> <p>Due to (or as a consequence of):</p> <p>b. <i>Arteriosclerotic Cardiovascular disease</i></p> <p>Due to (or as a consequence of):</p> <p>c. <i>Diabetes</i></p> <p>Due to (or as a consequence of):</p> <p>d.</p>										
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
<p><i>Decomposition</i></p> <p><i>Hypertension</i></p>										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier						
29c. License number D08358				29d. Date signed (Month, Day, Year) 8/5/96						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GRACIE V. PATRICK 8903 HARTFORD ROAD										
31. Date filed (Month, Day, Year) AUG 06 1996				32. Registrar's Signature Davidson-Hendall						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ITEM: 1. PER F.H. FILM g-738
8/6/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23182

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ISABELLE GYSIN GYSIN				2. Date of Death Month Day Year AUGUST 3, 1996		3. Time of Death 9:40 PM	
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A	
Funeral Director	5. Social Security Number 220-37-5355	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Apr. 12, 1913	9. Birthplace (State or Foreign Country) Switzerland	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Severna Park			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 750 Cypress Road			10f. Zip Code 21146		10g. Citizen of What Country? Switzerland		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 yrs.		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Edwin Welti				18. Mother's Name (First, Middle, Maiden Surname) Elisa Tscherter			
	19a. Informant's Name/Relationship (Type, Print) Nellie Gysin Pilert/Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 750 Cypress Rd. Severna Park, MD 21146				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date Aug. 6, 1996	20c. Location - City or Town, State Catonsville, MD		
	21. Signature of Funeral Service Licensee Bri L. Ebaugh			22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Hwy. S.E. Glen Burnie, MD 21061				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiogenic Shock Due to (or as a consequence of): b. Mitral Valve Regurgitation Due to (or as a consequence of): c. Mitral valve prolapse Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 6 hours 1 + 1/2 weeks 60 years.
	Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Cholecystitis						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and Title of certifier SURGICAL RESIDENT KAHLIL ANDREWS, MD			29c. License number N1262		29d. Date signed (Month, Day, Year) 08-03-1996		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAHLIL ANDREWS, MD 600 N. Wolfe St Blalock 655 Baltimore, MD 21287							
State Registrar	31. Date filed (Month, Day, Year) AUG 06 1996		32. Registrar's Signature John Andrew Randall					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23183

ITEM: 8 per F.H. G-738 8/8/96 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) CHARLES GROSS				2. Date of Death Month August Day 2 Year 1996		3. Time of Death 6:20 AM			
	4a. Facility Name (If not institution, give street and number) Sinai Hospital				4b. City, Town, or Location of Death Balto		4c. County of Death N/A			
Funeral Director	5. Social Security Number 217-38-2366		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 12, 1940	9. Birthplace (State or Foreign Country) md		
	Usual Residence of Decedant									
To Be Completed by Funeral Director	10a. State md	10b. County N/A	10c. City, Town, or Location Balto			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number 5509 Nome Ave			10f. Zip Code 21215		10g. Citizens of What Country? U.S.A.				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedant Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) N/A		18a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Booth Cleaner			16b. Kind of Business/Industry General motors				
	17. Father's Name (First, Middle, Last) Thomas Henry Gross				18. Mother's Name (First, Middle, Maiden Surname) Mamie Blackwell					
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Deborah Ann McCoy, Friend				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5509 Nome Ave Balto, md 21215					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		Data 8/7/96		20c. Location - City or Town, State Woodlawn, md			
	21. Signature of Funeral Service Licensee Blayne B. Harris				22. Name and Address of Facility March F. H. West 4300 Wabash Ave					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SQUAMOUS CELL LUNG CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Ellie G. Cohen MD		29c. License number AS 2402321-EC9008		29d. Date signed (Month, Day, Year) August 2, 1996				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital 2401 W. Belvedere Ave. Baltimore, MD 21215										
31. Date filed (Month, Day, Year) AUG 06 1996		32. Registrar's Signature Jodi Shuckor-Rodall								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23184

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Louis GREELY

2. Date of Death

Month Day Year
August 2, 1996

3. Time of Death

1:50 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital

4b. City, Town, or Location of Death

N/A

4c. County of Death

Baltimore

5. Social Security Number

171-07-5092

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 18, 1913

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

N/A

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

916 Catherine Avenue

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
11th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Iron Worker

16b. Kind of Business/Industry

Structural
Construction

17. Father's Name (First, Middle, Last)

Samuel Greely

18. Mother's Name (First, Middle, Maiden Surname)

Laura Keller

19a. Informant's Name/Relationship (Type, Print)

John Greely (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4903 Linda Avenue, Baltimore, Maryland 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Parkwood Cemetery

Date

8-5-96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home

9705 Belair Road, Baltimore, Maryland 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Cardiogenic shock

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 hour

b. Dilated cardiomyopathy

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 8 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

F. E. Chatham

29c. License number

D16960

29d. Date signed (Month, Day, Year)

August 2, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Frank Chatham 9000 Franklin Square Dr. Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

AUG 06 1996

32. Registrar's Signature

G. Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELLIOTTE WARREN HORTON Jr.

2. Date of Death

AUG. 02, 1996

Day Year

3. Time of Death

1244 PM

4a. Facility Name (If not institution, give street and number)

ST. AGNES HOSPITAL P.I.C.U

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

Funeral
Director

5. Social Security Number

NA

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

1996

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

Md

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2904 W. Lafayette Ave

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
NACollege (1-4 or 5+)
NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NA

16b. Kind of Business/Industry

NA

17. Father's Name (First, Middle, Last)

ELLIOTTE WARREN HORTON Sr.

18. Mother's Name (First, Middle, Maiden Surname)

April FAISON

19a. Informant's Name/Relationship (Type, Print)

April HORTON - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2904 W. Lafayette Ave Balto. Md. 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Mem Pk

Date

8/7/96

20c. Location - City or Town, State

Arbutus, Md

21. Signature of Funeral Service Licensee

Thymus B. Harris

22. Name and Address of Facility

MARCH FUNERAL HOME - WEST
4300 Wabash Ave. Balto md. 21215

23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PREMATUREITY WITH COMPLICATIONS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

XX Yes 2 ☐ No

Hospital:

XX Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicida 4 ☐ Homicida

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.XX ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Donald G Wright MD

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

AUG. 3, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DONALD G WRIGHT MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 06 1996

32. Registrar's Signature

John Davidson

State
Registrar

Baltimore, Maryland 21215-0020

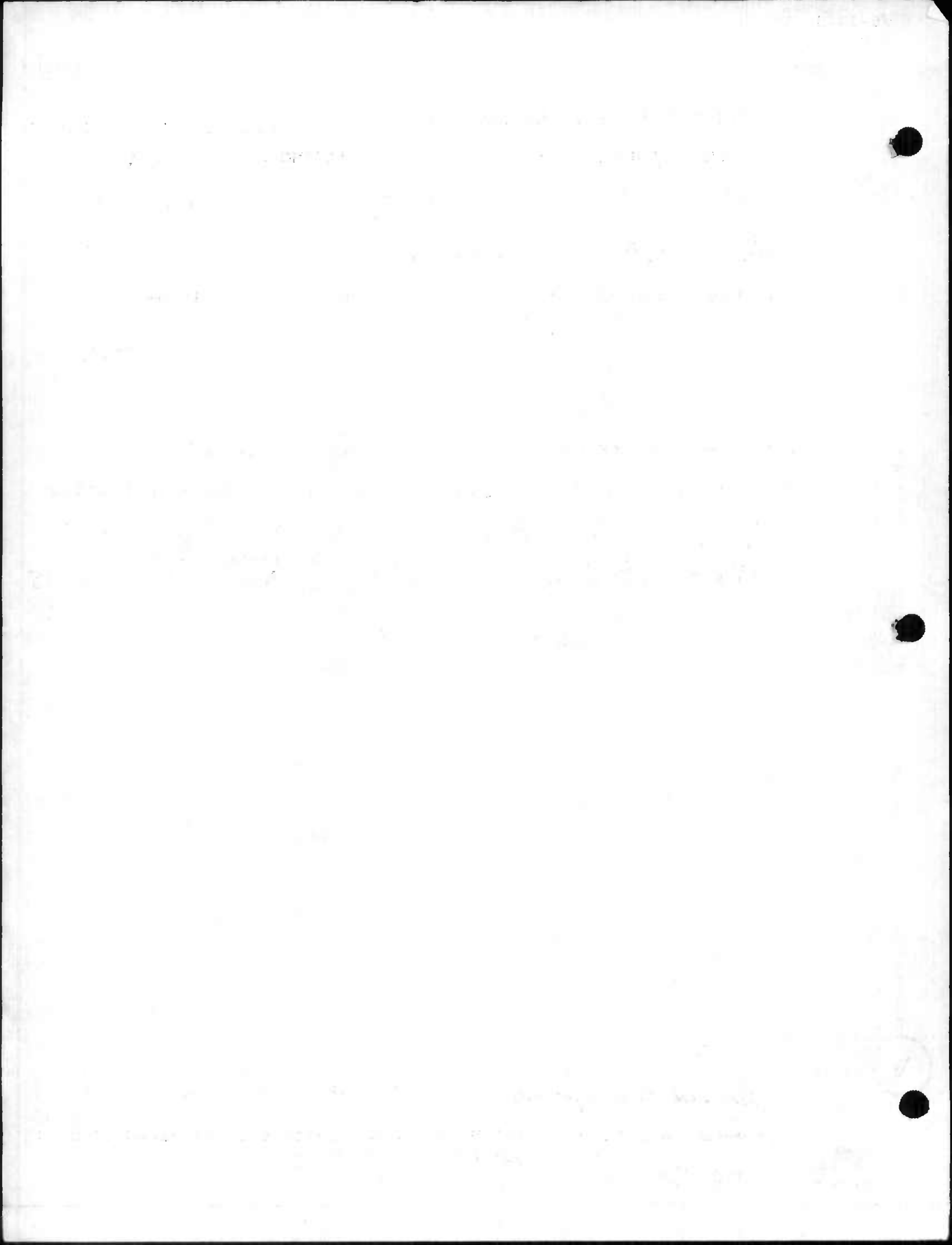
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23186

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LOUISE Mutter HENSLEY				2. Date of Death Month Day Year AUGUST 02, 1996		3. Time of Death 0003AM	
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL E.R.				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A	
Funeral Director	5. Social Security Number 226-90-0796		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 18, 1924	
	9. Birthplace (State or Foreign Country) Virginia		10a. State Va.		10b. County Wise		10c. City, Town or Location Coeburn	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 702 Salem Ave. N. E.		10f. Zip Code 24230		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Home		17. Father's Name (First, Middle, Last) Robert Harvey Mutter	
	18. Mother's Name (First, Middle, Maiden Surname) Coralee Bell Castle		19a. Informant's Name/Relationship (Type, Print) Janie H. Thompson		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Coeburn, Virginia 24230		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Greenwood Mem. Gar.		20c. Date 8-5		20d. Location - City or Town, State Virginia		21. Signature of Funeral Service Licensee 	
	22. Name and Address of Facility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	23c. Was an autopsy performed? INSPECTION <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		24. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	26. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		27. Date of Injury (Month, Day Year) 28e. Time of Injury M		27. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) AUGUST 02, 1996	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201		31. Date filed (Month, Day, Year) AUG 06 1996		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23187

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>TIMMY HARRIS</i>				2. Date of Death Month <i>July</i> Day <i>30</i> Year <i>96</i>		3. Time of Death <i>3:55 PM</i>													
	4a. Facility Name (If not institution, give street and number) <i>Church Home Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>													
Funeral Director	5. Social Security Number <i>212-78-4096</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>36</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>7-28-60</i>	9. Birthplace (State or Foreign Country) <i>USA MD</i>												
	Usual Residence of Decedent																			
To Be Completed by Funeral Director	10a. State <i>MD</i>	10b. County <i>N/A</i>	10c. City, Town or Location <i>Baltimore</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No														
	10e. Street and Number <i>317 Dallas Court</i>			10f. Zip Code		10g. Citizen of What Country? <i>USA</i>														
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>													
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> Collage (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>unemployed</i>			16b. Kind of Business/Industry <i>N/A</i>														
	17. Father's Name (First, Middle, Last) <i>George Brooks Jr.</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Gloria Harris</i>															
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>George Brooks Jr.</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1936 Clifton Ave. Baltimore, MD. 21216</i>															
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>mt. Zion Cemetery</i>		Date <i>8/3/96</i>	20c. Location - City or Town, State <i>Landsdowne, MD</i>														
	21. Signature of Funeral Service Licensee <i>Jeff Miller</i>				22. Name and Address of Facility <i>Jeff Miller Funeral Home PC 1639 W. Broadway, Baltimore, MD 21213</i>															
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
	Approximate Interval Between Onset and Death																			
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. <i>PNEUMONIA</i></td> <td>Due to (or as a consequence of):</td> <td><i>24 Hrs</i></td> </tr> <tr> <td>b. <i>LIVER FAILURE</i></td> <td>Due to (or as a consequence of):</td> <td><i>24 Hrs</i></td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <i>PNEUMONIA</i>	Due to (or as a consequence of):	<i>24 Hrs</i>	b. <i>LIVER FAILURE</i>	Due to (or as a consequence of):	<i>24 Hrs</i>	c.	Due to (or as a consequence of):		d.	Due to (or as a consequence of):	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <i>PNEUMONIA</i>	Due to (or as a consequence of):	<i>24 Hrs</i>																	
	b. <i>LIVER FAILURE</i>	Due to (or as a consequence of):	<i>24 Hrs</i>																	
	c.	Due to (or as a consequence of):																		
	d.	Due to (or as a consequence of):																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>CHOLELITHIASIS</i> <i>HYPoxic ENCEPHALOPATHY</i> <i>INTRAVENOUS DRUG ABUSE</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown														
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred												
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>A. J. [Signature]</i>		29c. License number <i>021338</i>		29d. Date signed (Month, Day, Year) <i>July-30-1996</i>														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>ALAN SWEAST, Church Home Hospital Baltimore</i>																				
31. Date filed (Month, Day, Year) <i>AUG 06 1996</i>																				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23188

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALBERT HOFFENBERG				2. Date of Death Month <u>August</u> Day <u>3</u> Year <u>96</u>		3. Time of Death <u>618 AM</u>	
	4e. Facility Name (If not institution, give street and number) NORTH OAKS HEALTH CENTER				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 176-01-2178		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) FEB. 11, 1904	
	9. Birthplace (State or Foreign Country) MD							
Usual Residence of Decedent								
10e. State MD		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 725 MT. WILSON LANE				10f. Zip Code 21208		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MANAGER		16b. Kind of Business/Industry TRANSPORTATION		
17. Father's Name (First, Middle, Last) BENJAMIN HOFFENBERG				18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN				
19a. Informant's Name/Relationship (Type, Print) FRANCES ENGELMAN (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2307 BRIGHTLEAF WAY; BALTIMORE, MD 21209				
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) CHIZUK AMUNO (ARLINGTON)		Date 8-4-96		20c. Location - City or Town, State BALTIMORE, MD	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, BALTIMORE, MD 21208				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)								
a. <u>Congestive Heart Failure</u> 3 days								
Due to (or as a consequence of):								
b. <u>Atherosclerotic Cardiovascular Disease</u> 20 years								
Due to (or as a consequence of):								
c. _____								
Due to (or as a consequence of):								
d. _____								
23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Mitral Valve Regurgitation</u>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28e. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D38675		29d. Date signed (Month, Day, Year) 8/3/96		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JOEL MESHULAM 1147 S HANOVER ST BALTIMORE MD 21230								
31. Date filed (Month, Day, Year) AUG 06 1996			32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

SECRET

BOY 30 AUG

96 23189

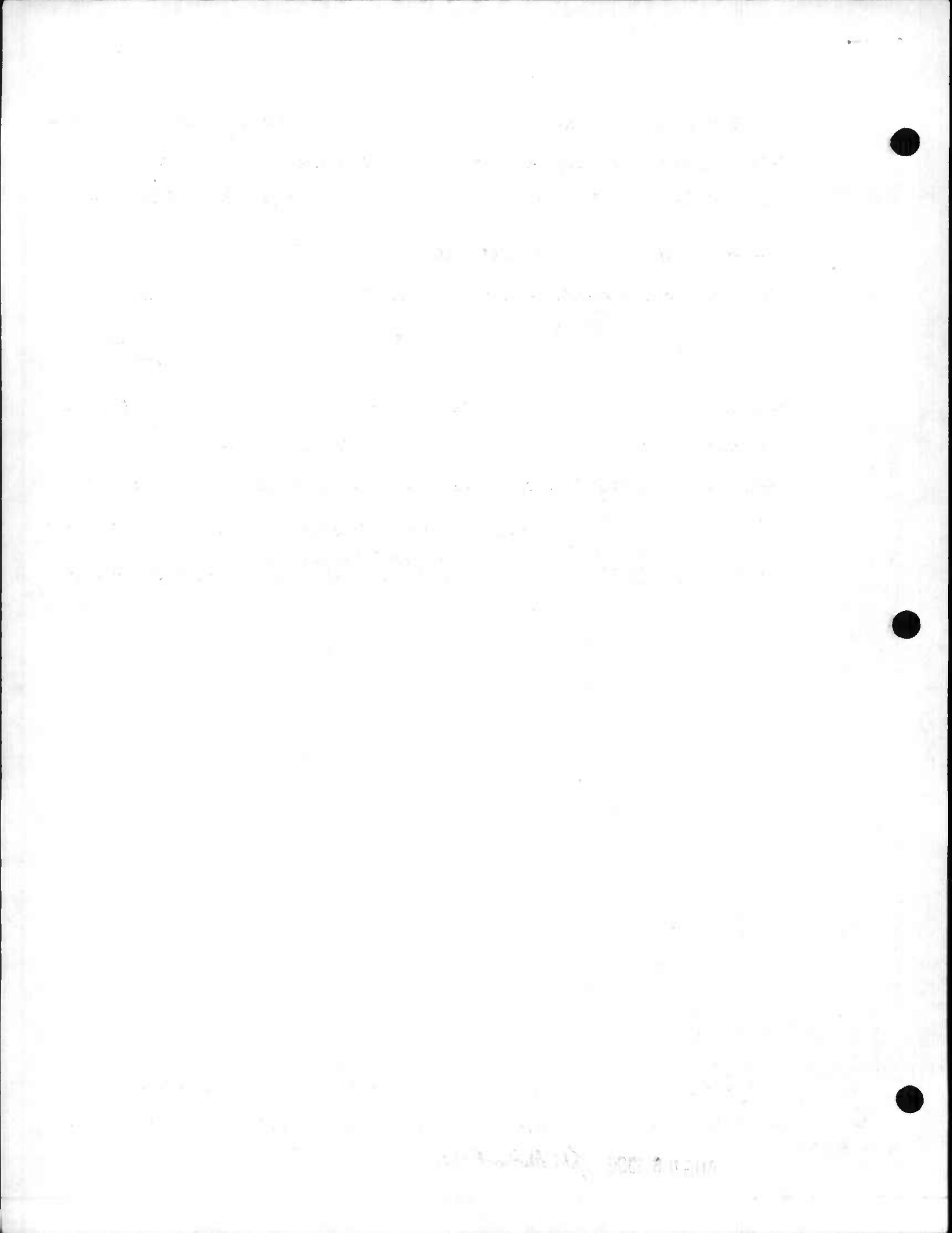
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carolyn Kohler Hecht				2. Date of Death Month Day Year August 4, 1996		3. Time of Death 1:58 AM																				
	4a. Facility Name (If not institution, give street and number) 6401 Loch Raven Boulevard (Apt. 222)				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A																				
Funeral Director	5. Social Security Number 218-07-0088A		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 97 Yrs.		8. Date of Birth (Month, Day, Year) April 22, 1899																				
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore																				
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 6401 Loch Raven Boulevard (Apt. 222)		10f. Zip Code 21239		10g. Citizen of What Country? U.S.A.																				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White																				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade College (1-4 or 5+) Credit Clerk		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department Store		16b. Kind of Business/Industry Department Store																						
	17. Father's Name (First, Middle, Last) Killian Kohler				18. Mother's Name (First, Middle, Maiden Surname) Barbara Unknown																						
	19a. Informant's Name/Relationship (Type, Print) JoAnn Hecht (Daughter-In-Law)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9123 Kilbride Road, Baltimore, Maryland 21236																						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Memorial Park Cem. 8-6		20c. Location - City or Town, State Baltimore, Maryland																						
	21. Signature of Funeral Service Licensee Robert Wodach				22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road, Baltimore, Maryland 21236																						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																										
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>CARDIAC ARREST.</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td>CARDIAC ARRHYTHMIA.</td> </tr> <tr> <td>c.</td> <td>HYPERTENSION.</td> </tr> <tr> <td>d.</td> <td>NON INSULIN DEPENDENT DIABETES MELLITUS</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a.	CARDIAC ARREST.	Approximate Interval Between Onset and Death	b.	CARDIAC ARRHYTHMIA.	c.	HYPERTENSION.	d.	NON INSULIN DEPENDENT DIABETES MELLITUS									
	Immediate Cause (Final disease or condition resulting in death)	a.	CARDIAC ARREST.	Approximate Interval Between Onset and Death																							
b.		CARDIAC ARRHYTHMIA.																									
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d.		NON INSULIN DEPENDENT DIABETES MELLITUS																									
<table border="1"> <tr> <td colspan="2">23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</td> </tr> <tr> <td>24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td>24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> </table>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																
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24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																										
<table border="1"> <tr> <td colspan="2">25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="2">26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="2">27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</td> <td colspan="2">28a. Date of Injury (Month, Day, Year) 8/5/96</td> </tr> <tr> <td colspan="2">28b. Time of Injury M</td> <td colspan="2">28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> <tr> <td colspan="2">28d. Describe how injury occurred</td> <td colspan="2">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> </tr> <tr> <td colspan="2">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> <td colspan="2"></td> </tr> </table>								25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 8/5/96		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)																									
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28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																									
28f. Location (Street and Number or Rural Route Number, City or Town, State)																											
<table border="1"> <tr> <td colspan="2">29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</td> </tr> <tr> <td>29b. Signature and title of certifier Dr. S. Srinivas</td> <td>29c. License number D22652</td> </tr> <tr> <td colspan="2">29d. Date signed (Month, Day, Year) 8/5/96</td> </tr> </table>								29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Dr. S. Srinivas	29c. License number D22652	29d. Date signed (Month, Day, Year) 8/5/96															
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																											
29b. Signature and title of certifier Dr. S. Srinivas	29c. License number D22652																										
29d. Date signed (Month, Day, Year) 8/5/96																											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. S. SRINIVAS 5601 LOCHRAVEN BLVD BALTIMORE MD 21239.																											
<table border="1"> <tr> <td>31. Date filed (Month, Day, Year) AUG 06 1996</td> <td>32. Registrar's Signature John Anderson-Randall</td> </tr> </table>								31. Date filed (Month, Day, Year) AUG 06 1996	32. Registrar's Signature John Anderson-Randall																		
31. Date filed (Month, Day, Year) AUG 06 1996	32. Registrar's Signature John Anderson-Randall																										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FASTINA FAUSTINA HIGGINS			2. Date of Death Month Day Year JULY 25 1996		3. Time of Death 6:24 P.M.	
	4a. Facility Name (If not institution, give street and number) MARYLAND GENERAL HOSPITAL			4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 215-66-0875		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 42 Yrs.	8. Date of Birth (Month, Day, Year) Nov. 18, 1953		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent 10a. State Maryland 10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 401 E. 25th Street Apt. 2H		10f. Zip Code 21218		10g. Citizen of What Country? United States		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unemployed		18b. Kind of Business/Industry never worked		
	17. Father's Name (First, Middle, Last) Gerald Walters			18. Mother's Name (First, Middle, Maiden Surname) Mary Higgins			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Rev. Cleola Johnson			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 401 E. 25th Street Apt. 2H, Baltimore, Maryland			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Memorial Gardens 8-6-96		20c. Location - City or Town, State Baltimore, Maryland		
	21. Signature of Funeral Service Licensee L. Valencia Holland		22. Name and Address of Facility March Funeral Home 1101 E. North Avenue, Baltimore, MD 21202				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Narcotic and cocaine intoxication Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.						
State Registrar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
					24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
					24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 7-25-96		28b. Time of Injury Unknown M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Unknown		28d. Describe how injury occurred Unknown		
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier L. Valencia Holland MD		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 26, 1996
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) J. L. LARSEN LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201						
31. Date filed (Month, Day, Year) AUG 06 1996		32. Registrar's Signature John Swanson-Randall					

Baltimore, Maryland 21215-0020

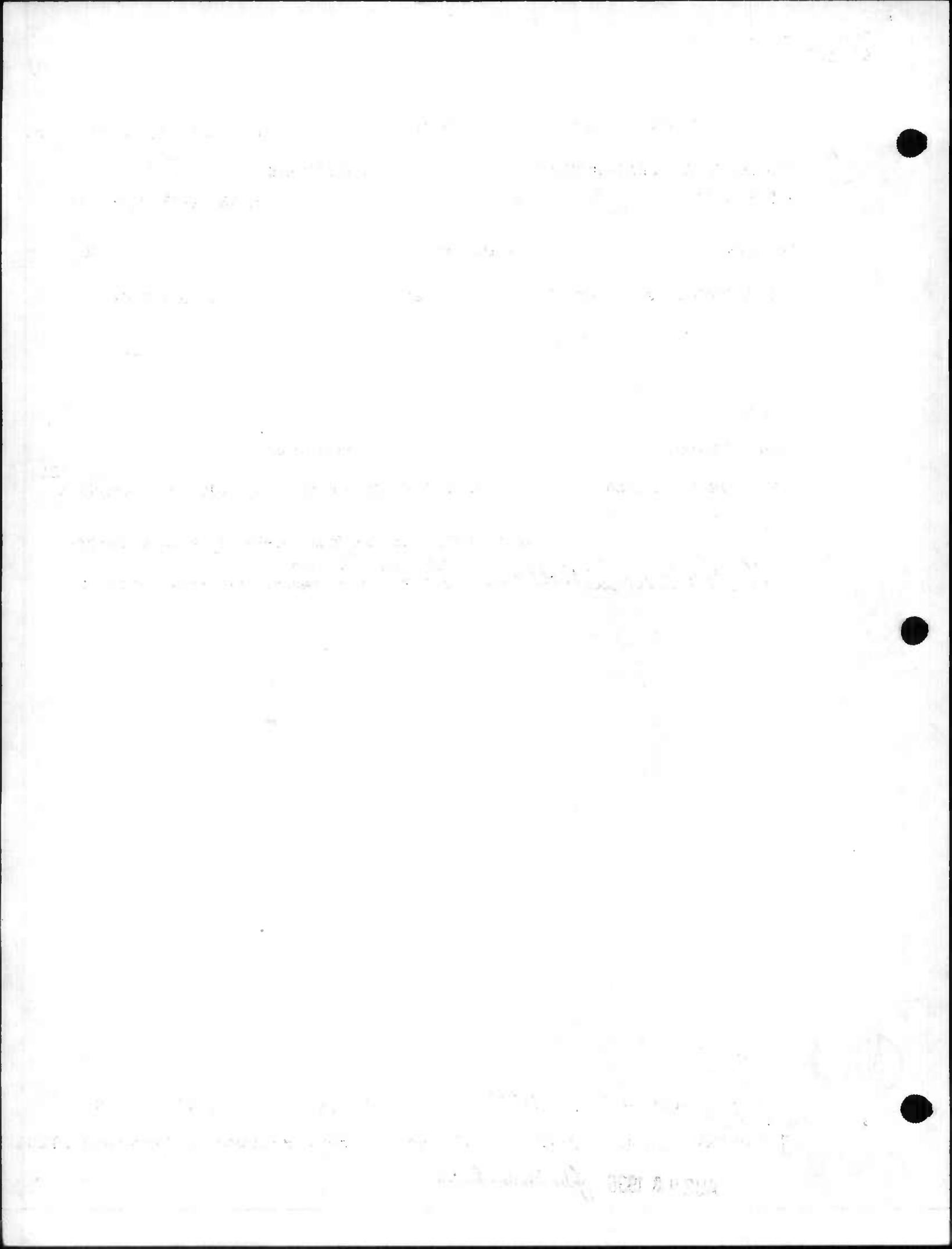
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed, it must be filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23191

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GOLDIE V. HINTON

2. Date of Death

Month Day Year
August 1, 1996

3. Time of Death

10:30 P.M.

4a. Facility Name (If not institution, give street and number)

Stellar Maris Hospice

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

244-12-9133

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
FEB. 1, 1913

9. Birthplace (State or Foreign Country)

N. Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2224 Barclay Street

10f. Zip Code

21218

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12th

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

State Hospital

17. Father's Name (First, Middle, Last)

Henry Coffey

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Pace

19a. Informant's Name/Relationship (Type, Print)

Edward E. Coffey

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7950 Jones \$Road, Jessup, MD 20794

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Arbutus Memorial Park

Date

8-6-96

20c. Location - City or Town, State

Arbutus, Maryland

21. Signature of Funeral Service Licensee

J. Valencia Holland

22. Name and Address of Facility

March Funeral Home

1101 E. NORTH AVENUE, BALTIMORE, MARYLAND 21202

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. *Myocardial Infarction*

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA26. Place of Death (Check only one)
Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Man W. Stenberg

29c. License number

D32543

29d. Date signed (Month, Day, Year)

8/12/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. Stenberg, 7505 Osler Drive, Towson, MD

31. Date filed (Month, Day, Year)

AUG 06 1996

32. Registrar's Signature

*Julia [Signature]*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23192

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LINDA IGNATIUS				2. Date of Death Month Day Year AUGUST 2, 1996		3. Time of Death 6:00 PM	
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A	
Funeral Director	5. Social Security Number 216-96-7647		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 32 Yrs.		8. Date of Birth (Month, Day, Year) Mar 4, 1964	
	9. Birthplace (State or Foreign Country) Washington, D.C.		10a. State Maryland		10b. County Carroll		10c. City, Town or Location Sykesville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 7118 Carmae Road		10f. Zip Code 21784		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4 or 5+) 4 + Masters		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Health Insurance Specialist		16b. Kind of Business/Industry Health Care Financing Administration			
	17. Father's Name (First, Middle, Last) Sylvester R. Adams				18. Mother's Name (First, Middle, Maiden Summa) Mary Ann Burgess			
	19a. Informant's Name/Relationship (Type, Print) Joseph C. Ignatius				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7118 Carme Rd. Sykesville, MD 21784			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Memorial Garden		20c. Location - City or Town, State Thurmont	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility 1212 W. Old Liberty Rd. Burrier-Queen Winfield, MD 21784			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pulmonary hypertension Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death 1 month							
	Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred	
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Mark Lewis MD		29c. License number M6321		29d. Date signed (Month, Day, Year) August 2, 1996	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Lewis Johns Hopkins Hosp. Baltimore Maryland								
State Registrar	31. Date filed (Month, Day, Year) AUG 06 1996		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

ITEMS: 14. & 16b, PER F.H.
FILM g-738 8/6/96 t.t

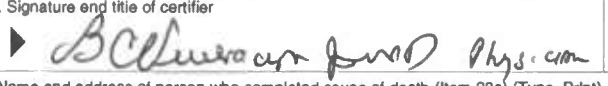
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23193

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Hurley Edwards				2. Date of Death Month 7 Day 26 Year 1996		3. Time of Death 1:37 pm						
	4a. Facility Name (If not institution, give street and number) Greenspring Nursing and Rehab. Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore City						
Funeral Director	5. Social Security Number 219-98-4257		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 28 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 8-22-67	9. Birthplace (State or Foreign Country) P.G. Co.					
	Usual Residence of Decedent												
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore City			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
10e. Street and Number 4615 Park Heights Avenue				10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.							
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black						
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) No				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpentry			16b. Kind of Business/Industry IMPROVEMENT Home Improvement						
17. Father's Name (First, Middle, Last) Marshall Johnson				18. Mother's Name (First, Middle, Maiden Surname) Patrishia Jones									
19a. Informant's Name/Relationship (Type, Print) Terrasita Jones/Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36 S. Exeter Street, Balto., MD 21202									
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Cemetary		Date 8-7-96		20c. Location - City or Town, State Baltimore City							
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Irvin Carroll Funeral Home 1712 W. North Avenue									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Respiratory Failure days Due to (or as a consequence of): b. ACQUIRED IMMUNODEFICIENCY SYNDROME YEARS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. History of Intravenous Drug Abuse Severe Anemia								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier 		29c. License number 013664		29d. Date signed (Month, Day, Year) 7/26/96	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. C. VENERACION JR MD PA. 1576 MERRITT BLVD BALTO MD 21204													
31. Date filed (Month, Day, Year) AUG 06 1996				32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23194

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ERNEST

JONES

2. Date of Death

Month

Day

Year

Aug. 2, 1996

3. Time of Death

3:35 AM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

213-44-5191

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Feb. 21, 1922

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

#4 Woodland Court

10f. Zip Code

20707

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces? ☒ unknown
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
unknownCollege (1-4 or 5+)
unknown16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Summa)

unknown

19a. Informant's Name/Relationship (Type, Print)

Bob Myers/Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unknown

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, dir.

22. Name and Address of Facility

State Anatomy Board-655 W. Baltimore Street
Baltimore, Maryland 21201-155923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Ischemic Heart Disease

Due to (or as a consequence of):

Years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Myocardial infarction

Due to (or as a consequence of):

Unknown

c. Coronary insufficiency

Due to (or as a consequence of):

Years

d. Severe coronary atherosclerosis

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertipidemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

N/A

28b. Time of Injury

N/A

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

N/A

28d. Describe how injury occurred

N/A

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William Fox

Attending
Physician

29c. License number

D-37245

29d. Date signed (Month, Day, Year)

8-2-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Fox, MD 13635 Baltimore Ave. Laurel, MD 20707

State
Registrar

31. Date filed (Month, Day, Year)

AUG 06 1996

32. Registrar's Signature

Julia Anderson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

ITEM: 1. PER F.H. FILM G-738 8/6/96 t.t										96 23195					
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.					
1 - STATE REGISTRAR										CERTIFICATE OF DEATH					
1. DECEDENT'S NAME (First, Middle, Last) Tresa E. James TRESA E. JAMES					2. DATE OF DEATH MONTH DAY YEAR August 01 1996			3. TIME OF DEATH 3:50 AM							
4. SOCIAL SECURITY NUMBER 217-22-1386		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 97 YRS.	7. DATE OF BIRTH (Month, Day, Year) Dec. 20, 1898		8. BIRTHPLACE (State or Foreign Country) Maryland									
9a. FACILITY NAME (If not institution, give street and number) Mercy Medical Center					9b. CITY, TOWN OR LOCATION OF DEATH Baltimore			9c. COUNTY OF DEATH Baltimore							
RESIDENCE OF DECEDENT															
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO								
10e. STREET AND NUMBER 615 South Decker Avenue				10f. ZIP CODE 21224		10g. CITIZEN OF WHAT COUNTRY? U.S.A.									
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White								
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th grade College (1-4 or 5+) College			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Own Home									
17. FATHER'S NAME (First, Middle, Last) Joseph Creamer					18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Platt										
19a. INFORMANT'S NAME (Type/Print) Patricia James (Daughter)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 South Decker Avenue, Baltimore, Maryland 21224											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Most Holy Redeemer Cemetery 8-5			DATE August 01, 1996		20c. LOCATION — City or Town, State Baltimore, Maryland								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Maryland 21213											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Uroperis DUE TO (OR AS A CONSEQUENCE OF): b. Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 1 wk 2 years															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. SIGNATURE AND TITLE OF CERTIFIER Matthew J. Walters MD		29c. LICENSE NUMBER P08676		29d. DATE SIGNED (Month, Day, Year) August 01, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Matthew J. Walters MD															
31. DATE FILED (Month, Day, Year) AUG 06 1996		32. REGISTRAR'S SIGNATURE John Andrew Randall													

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 23196

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WALTER A. JONES Jr.

2. Date of Death

Month August Day 1, Year 1996

3. Time of Death

9:45 A.M.

4a. Facility Name (If not institution, give street and number)

Overlea Gardens Nursing Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

215-03-6583

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MAY 16, 1916

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1034 Valley Street

10f. Zip Code

21202

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

laborer

16b. Kind of Business/Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

Walter Jones, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Rosa James

19a. Informant's Name/Relationship (Type, Print)

Lillian Jones

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1034 Valley Street, Baltimore, MD 21202

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD National Park

Date

8-5-96

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

L. Valencia Holland

22. Name and Address of Facility

March Funeral Home

1101 E. North Avenue, Baltimore, MD 21202

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. METASTATIC PROSTATE CARCINOMA

Due to (or as a consequence of):

b. DEHYDRATION

Due to (or as a consequence of):

c. SMALL BOWEL OBSTRUCTION - RELEASE

Due to (or as a consequence of):

d. ANAEMIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

D 31464

29d. Date signed (Month, Day, Year)

8/3/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

821 N. EUTAW ST Suite 308, BALTIMORE MD 21201

31. Date filed (Month, Day, Year)

AUG 06 1996

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed and filed by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23197

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CAROLYN VIRGINIA KOLB

2. Date of Death

Month August 3, 1996 Day Year

3. Time of Death

1:00 PM

4a. Facility Name (If not institution, give street and number)

400 Overview Avenue

4b. City, Town, or Location of Death

Eastwood

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

219 38 0114

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

53

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
08 09 42

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Eastwood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

400 Overview Avenue

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housework

16b. Kind of Business/Industry

At Home

17. Father's Name (First, Middle, Last)

Ralph V Cavaliere

18. Mother's Name (First, Middle, Maiden Surname)

Anna Beran

19a. Informant's Name/Relationship (Type, Print)

Michael H. Kolb, Sr., Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

400 Overview Ave. Balto., Md. 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Oak Lawn Cemetery

Date

8-6-96

20c. Location - City or Town, State

Eastwood, Md.

21. Signature of Funeral Service Licensee

Charles S. Zeiler

22. Name and Address of Facility

Charles S. Zeiler & Son Inc.
6224 Eastern Ave. Balto., Md.23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. Due to (or as a consequence of):
CancerSequitally list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

>6 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Christopher J. Earley MD

29c. License number

D40987

29d. Date signed (Month, Day, Year)

8-5-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christopher J. Earley; 4940 Eastern Ave.; Baltimore MD 21224

31. Date filed (Month, Day, Year)

AUG 06 1996

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Jonathan Mary Kowaleski</i>				2. Date of Death Month <i>August</i> Day <i>3</i> Year <i>1996</i>		3. Time of Death <i>11 15 PM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Harford Memorial Hospital</i>				4b. City, Town, or Location of Death <i>Havre De Grace</i>		4c. County of Death <i>Harford</i>	
Funeral Director	5. Social Security Number <i>215-03-5554</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>76</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>08/22/1919</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>
	Usual Residence of Decedent							
10a. State <i>Maryland</i>		10b. County <i>Harford</i>		10c. City, Town or Location <i>Havre De Grace</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <i>4153 Quail Way</i>				10f. Zip Code <i>21078</i>		10g. Citizen of What Country? <i>U.S.A.</i>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4or 5+) <i>0</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Cable Inspector</i>			16b. Kind of Business/Industry <i>Western Electric</i>	
17. Father's Name (First, Middle, Last) <i>Peter Kowaleski</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Mary Pika</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Diana M. Personeus Niece</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4153 Quail Way Havre De Grace, Md 21078</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>St. Stanislaus Cemetery</i>		Date <i>8/7/96</i>		20c. Location - City or Town, State <i>Baltimore, Md</i>
21. Signature of Funeral Service Provider <i>[Signature]</i>				22. Name and Address of Facility <i>David J. Weber Funeral Home 401 S. Chester St. Baltimore, Md 21231</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>acute myocardial infarction</i> Due to (or as a consequence of): <i>coronary artery disease</i> Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <i>atherosclerotic cardiovascular disease</i> Due to (or as a consequence of): d. _____								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>hypertension, hypercholesterolemia, peripheral vascular disease, aortic artery stenosis</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>D37364</i>		29d. Date signed (Month, Day, Year) <i>AUGUST 4, 1996</i>
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>219 West Bel Air Avenue, Aberdeen, Maryland</i>								
31. Date filed (Month, Day, Year) <i>AUG 06 1996</i>				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23199

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Clara Augusta Kilheffer

2. Date of Death

Month Day Year
Aug. 3, 1996

3. Time of Death

4:00 P.M.

4a. Facility Name (If not institution, give street and number)

Crofton Convalescent Center

4b. City, Town, or Location of Death

Crofton

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

195-07-1992

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
2-1-1905

9. Birthplace (State or Foreign Country)

Pa.

Usual Residence of Decedent

10a. State

Md.

10b. County

Anne Arundel

10c. City, Town or Location

Crofton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2131 Davidsonville Road

10f. Zip Code

21114

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th grade N.A.

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Frederick Papenfus

18. Mother's Name (First, Middle, Maiden Surname)

Lizetta Schreck

19a. Informant's Name/Relationship (Type, Print)

Dawn Kilheffer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1126 Venetian Way Churchton, Md. 20733

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory

Date

8-5-96

20c. Location - City or Town, State

Balto. Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

12 Ridgely Ave. Annap. Md.
Hardesty Funeral Home P.A. 21401

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)Cardiopulmonary arrest
Due to (or as a consequence of):Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Senile dementia - Alzheimer's type

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Nancy D. Rivera-Cassell, MD

29c. License number

D40904

29d. Date signed (Month, Day, Year)

8-4-96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Nancy D. Rivera-Cassell MD, 138A Mayo Rd., EDGEWATER, Md 21037

31. Date filed (Month, Day, Year)

AUG 06 1996

32. Registrar's Signature

John Davidson

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23200

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>William Karl</i>				2. Date of Death Month <i>August</i> Day <i>3</i> Year <i>1996</i>		3. Time of Death <i>1 p.m.</i>	
	4a. Facility Name (If not institution, give street and number) CHURCH HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 086-28-0868		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 11-16-1905	
	9. Birthplace (State or Foreign Country) GERMANY							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 101 NORTH BOND STREET				10f. Zip Code 21231		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8YRS.		College (1-4 or 5+)		18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) UPHOLSTERER		16b. Kind of Business/Industry UPHOLSTERY WORK	
	17. Father's Name (First, Middle, Last) WILLIAM KARL				18. Mother's Name (First, Middle, Maiden Surname) FREDERICKA KUSS			
	19a. Informant's Name/Relationship (Type, Print) WILLIAM J. KARL				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 S. COLLINGTON AVE. BALTO., MD. 21231.			
	20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) QUAKER CEMETERY		Date 8/8/96		20c. Location - City or Town, State CHAPPAQUA, N.Y.	
	21. Signature of Funeral Service Licensee <i>William R. Davis III</i>				22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212.			
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)		a. <i>Pneumonia</i> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <i>Days</i>			
	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		b. <i>Congestive heart failure with pleural effusions</i> Due to (or as a consequence of):		<i>Months</i>			
			c. <i>Senile dementia</i> Due to (or as a consequence of):		<i>Years</i>			
			d. <i>Chronic Atrial fibrillation</i> Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospitel: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D40525		29d. Date signed (Month, Day, Year) 8/31/96		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Redif Ithugi, M.D. Church Hospital								
31. Date filed (Month, Day, Year) AUG 06 1996		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23201

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LINDA J KINGSTON				2. Date of Death Month AUG. Day 03, Year 1996		3. Time of Death 1510 PM	
	4a. Facility Name (If not institution, give street and number) 3501 ST. PAUL STREET				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funeral Director	5. Social Security Number 105-46-2154		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 35 Yrs.		8. Date of Birth (Month, Day, Year) June 1, 1961	
	9. Birthplace (State or Foreign Country) N.Y.		10a. State Md.		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 3501 St. Paul St.		10f. Zip Code 21218		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (14 or 5+) 3		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Food Service		16b. Kind of Business/Industry Service			
	17. Father's Name (First, Middle, Last) William J Kingston				18. Mother's Name (First, Middle, Maiden Surname) Barbara Louise Walter			
	19a. Informant's Name/Relationship (Type, Print) William J. Kingston/Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mustone Ct. Towson, Md. 21204			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory, or other place) Sadsbury Friends Burial Ground		20c. Location - City or Town, State 8/10/96 Gap, Pa.			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Multiple Injuries Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last f. _____ Due to (or as a consequence of): g. _____ Due to (or as a consequence of): h. _____ Due to (or as a consequence of):							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 8/3/96		28b. Time of Injury 1500 HR		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred subject jumped from apartment building		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) apartment building		28f. Location (Street and Number or Rural Route Number, City or Town, State) 3501 Saint Paul Street in Baltimore, Maryland			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) AUG. 4, 1996			
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201							
	31. Date filed (Month, Day, Year) AUG 06 1996		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.


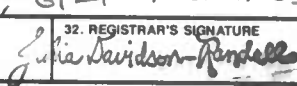
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

96 23202

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LILLY KROO				2. DATE OF DEATH MONTH JULY DAY 25 YEAR 1996		3. TIME OF DEATH 5:00 A M	
4. SOCIAL SECURITY NUMBER 047-26-1481		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10/28/1923	
9a. FACILITY NAME (If not institution, give street and number) THE HEBREW HOME OF GREATER WASH.				9b. CITY, TOWN OR LOCATION OF DEATH ROCKVILLE		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE MARYLAND				10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION BETHESDA	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 10250 WEST LAKE DRIVE #811			
10f. ZIP CODE 20817				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OWNER		16b. KIND OF BUSINESS/INDUSTRY DRYCLEANERS	
17. FATHER'S NAME (First, Middle, Last) ISAAC EPHRAIM FISCHER RUBIN				18. MOTHER'S NAME (First, Middle, Maiden Surname) RACHEL ROSENBAUM			
19a. INFORMANT'S NAME (Type/Print) EDITH ALEXANDER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2001 HOPEWOOD DRIVE FALLS CHURCH, VA 22043			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING DAVID MEMORIAL GARDENS 7/28		20c. LOCATION — City or Town, State FALLS CHURCH, VA		20d. DATE 7/28	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY IVES-PEARSON FUNERAL HOMES FALLS CHURCH, VA 22046			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. GLIOSAR COMA (BRAIN TUMOR)							
Due to (or as a consequence of):							
b. Due to (or as a consequence of):							
c. Due to (or as a consequence of):							
d. Due to (or as a consequence of):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER P. Talwar, M.D.				29c. LICENSE NUMBER D 36552		29d. DATE SIGNED (Month, Day, Year) JULY 25 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) P. TALWAR, 6121 MONTROSE ROAD, ROCKVILLE MD. 20852							
31. DATE FILED (Month, Day, Year) AUG 06 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23203

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LEON LERNER				2. Date of Death Month Day Year AUGUST 01 96		3. Time of Death 6:35 PM		
	4a. Facility Name (If not institution, give street and number) SAINT JOSEPH MEDICAL CENTER				4b. City, Town, or Location of Death TOWSON, MD		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 215-09-9816		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) DEC. 15, 1909		
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 6711 PARK HEIGHTS AVE., APT. 208		10f. Zip Code 21215		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALESMAN		16b. Kind of Business/Industry LIQUOR		17. Father's Name (First, Middle, Last) JACOB LERNER		18. Mother's Name (First, Middle, Maiden Surname) SARAH SHARFMAN	
19a. Informant's Name/Relationship (Type, Print) MRS. SUE LERNER (WIFE)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6711 PARK HEIGHTS AVE., APT. 208 BALTIMORE, MD 21215		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ANSHE NEISEN		20c. Location - City or Town, State 8-4-1996- ROSEDALE, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Sol Levinson & Bros., Inc. 8900 Reisterstown Road Pikesville, MD 21208		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. CONGESTIVE HEART FAILURE DUE TO Due to (or as a consequence of): b. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR Due to (or as a consequence of): c. DISEASE Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 2 MONTHS YEARS			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury et Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D19508		29d. Date signed (Month, Day, Year) 1st August 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIVIDAD D. DE LEON M.D. 7620 YORK ROAD, TOWSON, MARYLAND 21204		31. Date filed (Month, Day, Year) AUG 06 1996		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Handwritten text at the bottom of the page, including a signature and some illegible notes.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23204

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Evelyn Lucas				2. Date of Death Month Day Year July 30 1996				3. Time of Death 3:10 pm		
	4a. Facility Name (If not institution, give street and number) North Charles Health Center Baltimore Md.				4b. City, Town, or Location of Death				4c. County of Death		
Funeral Director	5. Social Security Number 223-22-0008		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) Oct 28, 1928		9. Birthplace (State or Foreign Country) VA		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State Md		10b. County NIA		10c. City, Town or Location Balto				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 2528 Druid Hill Ave apt 1				10f. Zip Code 21217		10g. Citizen of What Country? U.S.A				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th NIA		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self-Employed				16b. Kind of Business/Industry Lounge & Restaurant				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Thomas H. Corbin sr.				18. Mother's Name (First, Middle, Maiden Surname) Lydia Cooke						
	19a. Informant's Name/Relationship (Type, Print) Mildred M. Ware-Neice				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 842 Allendale St. Balto, Md 21229						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cooke Cemetery		Data 8/3/96		20c. Location - City or Town, State Bena, Va.				
	21. Signature of Funeral Service Licensee Anthony E. Ward				22. Name and Address of Facility Mann & H. West 4300 Wabash Ave						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Breast Cancer with bone, liver and brain metastases. Due to (or as a consequence of):								Approximate Interval Between Onset and Death		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):										
	c. Due to (or as a consequence of):										
	d. Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier Randy Miller MD				29c. License number D47683				29d. Date signed (Month, Day, Year) 7/31/96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7220 Park Heights Avenue, Baltimore, MD 21208											
31. Date filed (Month, Day, Year) AUG 06 1996		32. Registrar's Signature John Andrew Randall									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEM: 1. PER F..H FILM G-738

State of Maryland / Department of Health and Mental Hygiene

96 23205

8/6/96 t.t

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>BURT L. LICHTIG</u> BERT L. LICHTIG				2. Date of Death Month <u>AUG</u> Day <u>3</u> Year <u>1996</u>		3. Time of Death <u>5:00AM</u>		
	4a. Facility Name (If not institution, give street and number) HOWARD COUNTY GENERAL HOSPITAL				4b. City, Town, or Location of Death COLUMBIA		4c. County of Death HOWARD		
Funeral Director	5. Social Security Number 218-22-0557		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) DEC. 14, 1905	9. Birthplace (State or Foreign Country) OHIO	
	Usual Residence of Decedent								
10a. State MD		10b. County HOWARD		10c. City, Town or Location COLUMBIA			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 5400 VANTAGE POINT ROAD APT. 414				10f. Zip Code 21044		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ARCHITECT			16b. Kind of Business/Industry ARCHITECTURE			
17. Father's Name (First, Middle, Last) MAX LICHTIG				18. Mother's Name (First, Middle, Maiden Surname) GAZELLA UNKNOWN					
19a. Informant's Name/Relationship (Type, Print) JANICE KIRSH - DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10221 TUSCANY ROAD ELLICOTT CITY, MD 21042					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) HAR SINAI CONG.		20c. Location - City or Town, State 8/4/96 REISTERSTOWN, MD			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Sol Levinson & Bros., Inc. 8900 Reisterstown Road Pikesville, MD 21208					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <u>ISCHEMIC CARDIOMYOPATHY</u> Due to (or as a consequence of): b. <u>CORONARY ARTERY DISEASE</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death <u>ONE YEAR</u> <u>ONE YEAR</u>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ACUTE RENAL FAILURE</u>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <u>N/A</u>		28b. Time of injury <u>N/A</u> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <u>N/A</u>	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <u>N/A</u>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <u>N/A</u>							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>F. Kotler, M.D.</u>							
29c. License number <u>MD50500</u>		29d. Date signed (Month, Day, Year) <u>AUGUST 3, 1996</u>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>FREDERICK KOTLER, M.D. 11055 LITTLE PATUXENT Pkwy SUITE 205 COLUMBIA MD 21044</u>									
31. Date filed (Month, Day, Year) <u>AUG 06 1996</u>		32. Registrar's Signature <u>Johanna Anderson-Randall</u>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23206

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ESTHER M. LEVY

2. Date of Death

JULY 31, 1996

3. Time of Death

9:17pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

MILFORD MANOR NURSING HOME

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

213-48-5827

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

92

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

APR. 30, 1904

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

NA/

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6992 MILBROOK PARK DRIVE, APT. A-1

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

XX ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

NATHAN

LEVY

18. Mother's Name (First, Middle, Maiden Surname)

SARA

HOFFMAN

19a. Informant's Name/Relationship (Type, Print)

MR. AARON SMELKINSON (ATTORNEY)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6958 BROOKMILL ROAD BALTIMORE, MD 21215

20a. Method of Disposition

X ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ADATH YESHURUN

Date

8-2-1996

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

Sol Levinson

22. Name and Address of Facility

Sol Levinson & Bros., Inc.

8900 Reisterstown Road Pikesville, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

C. Levinson

29c. License number

D17075

29d. Date signed (Month, Day, Year)

8 2 96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel Levin 10219 S. Doldale Rd. Ow. Mills 2117

State
Registrar

31. Date filed (Month, Day, Year)

AUG 06 1996

32. Registrar's Signature

C. Levinson

Baltimore, Maryland 21215-0020
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

THE
OFFICE OF THE
SECRETARY OF THE
NAVY
WASHINGTON, D. C.

TO THE
HONORABLE
MEMBERS OF THE
HOUSE OF REPRESENTATIVES
AND
THE SENATE

IN RESPONSE TO
A RESOLUTION
PASSED BY THE
HOUSE OF REPRESENTATIVES
ON MAY 1, 1917
RELATIVE TO THE
NAVY

REPORT
ON THE
NAVY
FOR THE YEAR
1917
BY
THE
SECRETARY OF THE
NAVY
JAMES D. COOPER
1918

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23207

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT E. LEWIS

2. Date of Death

JULY 29, 1996

3. Time of Death

5:00 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

215-24-5276

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

10-24-1904

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

MD.

10b. County

Baltimore

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2017 Western Run Road

10f. Zip Code

21030

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Architect

16b. Kind of Business/Industry

Architecture

17. Father's Name (First, Middle, Last)

Omer Stockman Lewis

18. Mother's Name (First, Middle, Maiden Surname)

Anna Beggs

19a. Informant's Name/Relationship (Type, Print)

Craig Lewis/ son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1000 Rolandvue Ave, Ruxton, MD 21204

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery 8-1

Date

20c. Location - City or Town, State

Baltimore, MD.

21. Signature of Funeral Service Licensee

R. G. Rutter

22. Name and Address of Facility

HENRY W. JENKINS AND SONS COMPANY

4905 YORK ROAD, BALTIMORE, MARYLAND, 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCT

Due to (or as a consequence of):

2 DAYS.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ANCINA > 10YRS, GLANT CELL

ARTERITIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Daniel G. Sapir

29c. License number

010670

29d. Date signed (Month, Day, Year)

JULY 30, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DANIEL G. SAPIR M.D., 10755 FALLS ROAD, LUTHERVILLE, MARYLAND, 21093

State
Registrar

31. Date filed (Month, Day, Year)

AUG 06 1996

32. Registrar's Signature

Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23208

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDITH C. LESTER

2. Date of Death

08 01-1996

3. Time of Death

8:31pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

8310 CARRBRIDGE CIRCLE

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

212-03-6225

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

05-06-1906

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

BALTIMORE

10c. City, Town or Location

TOWSON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8310 CARRBRIDGE CIRCLE

10f. Zip Code

21204

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 YRS.

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

HOMEMAKER

17. Father's Name (First, Middle, Last)

PAUL F. CULLISON

18. Mother's Name (First, Middle, Maiden Surname)

REBECCA COX

19a. Informant's Name/Relationship (Type, Print)

TAYLOR C. SHOULDICE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8310 CARRBRIDGE CIRCLE TOWSON, MD. 21204.

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

GRACE LAWN

Date

8/5/96

20c. Location - City or Town, State

NEW CASTLE, DE.

21. Signature of Funeral Service Licensee

William R. Pouch

22. Name and Address of Facility

HENRY W. JENKINS & SONS CO.

4905 YORK RD. BALTO., MD. 21212.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

b. COPD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

3 YRS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Francis X. Carmody

29c. License number

001373

29d. Date signed (Month, Day, Year)

8/2/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

FRANCIS X. CARMODY M.D. 7505 OSLER DRIVE TOWSON, MD. 21204.

31. Date filed (Month, Day, Year)

AUG 06 1996

32. Registrar's Signature

Francis X. Carmody

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

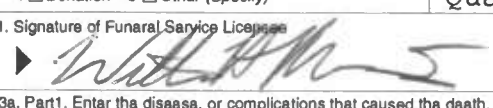
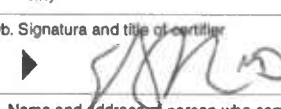
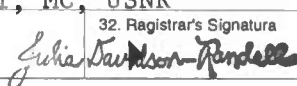
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23209

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CURTIS EUGENE LITTLE				2. Date of Death Month Day Year JULY 17 1996		3. Time of Death 2:35 PM	
	4a. Facility Name (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER				4b. City, Town, or Location of Death BETHESDA		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 239-14-8778		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) May 7, 1920	
	9. Birthplace (State or Foreign Country) North Carolina		10a. State VA		10b. County Prince William		10c. City, Town or Location Woodbridge	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1599 Katherine Court		10f. Zip Code 22191		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1960-1969		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Civil Service		16b. Kind of Business/Industry Navy			
	17. Father's Name (First, Middle, Last) Edgar Eugene Little				18. Mother's Name (First, Middle, Maiden Surname) Ruby Smith			
	19a. Informant's Name/Relationship (Type, Print) Laura Faye Little				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1599 Katherine Court, Woodbridge, VA 22191			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Quantico Nat. Cem.		Date 7/22/96		20c. Location - City or Town, State Triangle, VA	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Mountcastle Funeral Home 13318 Occoquan Rd., Woodbridge, VA 22191			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Causa (Final disease or condition resulting in death) a. MULTI ORGAN FAILURE Due to (or as a consequence of): b. SEPSIS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of causa of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number RES-000		29d. Date signed (Month, Day, Year) July 18, '96		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) S. J. CASH, LT, MC, USNR				31. Data filed (Month, Day, Year) AUG 06 1996				
32. Registrar's Signature 				33. Registrar's Name NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Walter R. Meise			2. Date of Death Month July Day 15 Year 96		3. Time of Death 11:36am				
	4a. Facility Name (If not institution, give street and number) Baltimore Veterans Hospital			4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore				
Funeral Director	5. Social Security Number 217 05 6653		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 7-15-16	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Md		10b. County Baltimore		10c. City, Town or Location Baltimore			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 1101- 2B Middleway Road				10f. Zip Code 21220		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)			16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self employed			16b. Kind of Business/Industry Tavern			
	17. Father's Name (First, Middle, Last) Richard W. Meise				18. Mother's Name (First, Middle, Maiden Surname) Matilda A. Hoffman					
	19e. Informant's Name/Relationship (Type, Print) Richard W. Meise				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 938 Foxridge Lane, Baltimore, Md. 21221					
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		Date 7-18-96		20c. Location - City or Town, State Baltimore, Md.		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hartley Miller Funeral Home 7527 Harford Rd., Baltimore Md. 21234					
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Septic Shock Due to (or as a consequence of): b. Multiple Organ Failure Due to (or as a consequence of): c. Klebsiella Bacteremia Due to (or as a consequence of): d. Pancreatitis								Approximate Interval Between Onset and Death 8 hours 3 days 4 days 1 week	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24e. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospital								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred		
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D47621		29d. Date signed (Month, Day, Year) 7/15/96				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) A. Rodriguez 2215 Clove Terrace Baltimore MD 21209										
31. Date filed (Month, Day, Year) AUG 06 1996		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

96-4206-510

CIP ITEMS: 23 PART I, 27, 28A-F
PER MEO FILM g-738 8/9/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23211

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM CHRISTOPHER

MALONE

2. Date of Death
Month Day Year
JULY 28, 19963. Time of Death
1:34 PM

4a. Facility Name (If not institution, give street and number)

IN FRONT OF 4717 HOMER AVENUE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

CITY

Funeral
Director

5. Social Security Number

246-13-4310

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

32 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
OCT 13 64

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD.

10b. County

CITY

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1938 MAUSPLEY CT

10f. Zip Code

21237

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

CONSTRUCTION

16b. Kind of Business/Industry

BUILDING

17. Father's Name (First, Middle, Last)

JAMES MALONE

18. Mother's Name (First, Middle, Maiden Surname)

MARY COLEY

19a. Informant's Name/Relationship (Type, Print)

MARY MALONE MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1938 MAUSPLEY CT. BALTO. MD. 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MT. ZION

Date

8-3-96

20c. Location - City or Town, State

BALTIMORE MD.

21. Signature of Funeral Service Licensee

Ronald A. Grayson

22. Name and Address of Facility

TRI-STATE FUNERAL SERV N.W. WASHINGTON D.C.
6234 3rd. st.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

NARCOTIC AND ALCOHOL INTOXICATION

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

ON STREET

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☒ Pending Investigation6 ☒ Could not be determined

28a. Date of Injury

(Month, Day, Year)

FOUND 7/28/96

28b. Time of Injury

1:20 P M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

FOUND IN CAR

28f. Location (Street and Number or Rural Route Number, City or Town, State)

FOUND IN FRONT OF 4717 HOMER AVE. BALTO. MD

29a. Certifier
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Margaret Bonehill

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 29, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAYSALE P. W. 111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

AUG 06 1996

32. Registrar's Signature

Davidson-Randall

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Page 1 of 1

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Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLOTTE MEIER				2. Date of Death Month JULY Day 30TH Year 1996		3. Time of Death 5:20 PM				
	4a. Facility Name (If not institution, give street and number) CHURCH HOME & HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A				
Funeral Director	5. Social Security Number 217-16-5288		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) APR. 21, 1901	9. Birthplace (State or Foreign Country) GERMANY			
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number 100 NORTH BROADWAY				10f. Zip Code 21231		10g. Citizen of What Country? USA				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PROPRIETOR		16b. Kind of Business/Industry DRAPERY						
	17. Father's Name (First, Middle, Last) NATHAN RISCH				18. Mother's Name (First, Middle, Maiden Surname) ADELE FRANK						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) MRS. MARTHA WEIMAN (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 SEMINARY DRIVE LUTHERVILLE, MD 21093						
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE HEBREW		Date 8-1-1996		20c. Location - City or Town, State REISTERSTOWN, MD				
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Sol Levinson & Bros., Inc. 8900 Reisterstown Road Pikesville, MD 21208						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): PULMONARY EDEMA Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):								Approximate interval between Onset and Death		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>[Signature]</i> Medical Specialist				29c. License number D 45280		29d. Date signed (Month, Day, Year) 7/30/96					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAJJAD MALICK 100 N Broadway, Baltimore, MD											
31. Date filed (Month, Day, Year) AUG 06 1996		32. Registrar's Signature <i>[Signature]</i>									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23213

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARVIN

MILLER

2. Date of Death

Month

Day

Year

JULY 31, 1996

3. Time of Death

0708AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

BON SECOURS HOSPITAL E.R.

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

NA

5. Social Security Number

219-50-4829

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month, Day, Year
11-9-48

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

312 FRANKLINTOWN ROAD

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

bus driver

16b. Kind of Business/Industry

Johnson Bus Co.

17. Father's Name (First, Middle, Last)

Joseph Miller

18. Mother's Name (First, Middle, Maiden Surname)

Loris Davis

19a. Informant's Name/Relationship (Type, Print)

LORETTA MILLER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5462 Bucknell Rd. Balto. Md 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MARYLAND VETERAN CEM.

Date

8/3/96

20c. Location - City or Town, State

OWNINGSWILL, MD.

21. Signature of Funeral Service Licensee

Jeff Miller

22. Name and Address of Facility

Jeff Miller F/H 1639 N. BROADWAY
BALTO. MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hypertensive Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

INSPECTION

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Theodore M. King

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 31, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Theodore King M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 06 1996

32. Registrar's Signature

Theodore King

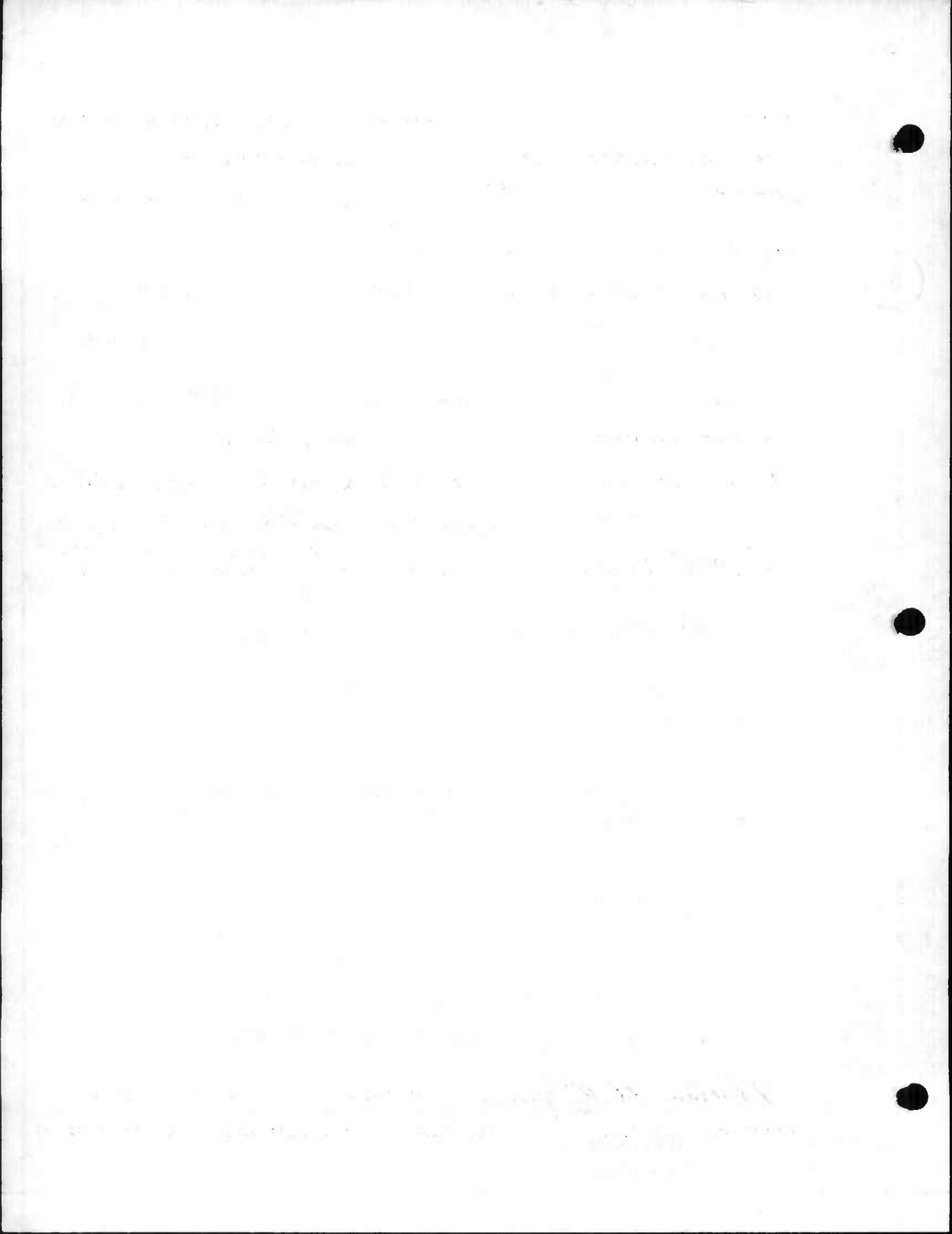
State Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23214

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MAZZATENTA, Vincent					2. Date of Death Month 8 Day 2 Year 1996		3. Time of Death 9:25 AM	
	4a. Facility Name (If not institution, give street and number) MERIDIAN FRANKLIN WOODS					4b. City, Town, or Location of Death ROSEDALE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 219-18-3179		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 02-15-1925		9. Birthplace (State or Foreign Country) VIRGINIA
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State PA.	10b. County LUZERNE		10c. City, Town or Location DRUMS			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number RD 2 BOX 727				10f. Zip Code 18222		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-1952		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) N/A			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PAYROLL SUPERVISER			16b. Kind of Business/Industry COMMERCIAL CREDIT		
	17. Father's Name (First, Middle, Last) ATTILIO A. MAZZATENTA					18. Mother's Name (First, Middle, Maiden Surname) FIANAMA PETRONIO			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) ELAINE A. MAZZATENTA (WIFE)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RD 2 BOX 727, DRUM, PENNSYLVANIA 18222			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PARK		Date 8/5/96		20c. Location - City or Town, State ELKRIDGE, MD.	
	21. Signature of Funeral Service Licensee 					22. Name and Address of Facility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061			
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
	<div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. GASTROINTESTINAL HEMORRHAGE</p> <p>Due to (or as a consequence of):</p> <p>b. RENAL FAILURE</p> <p>Due to (or as a consequence of):</p> <p>c. _____</p> <p>Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div> <p>Approximate Interval Between Onset and Death</p> <p>2 DAYS</p> </div> </div>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ISCHEMIC CARDIOMYOPATHY, DIABETES						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 					29c. License number D40008		29d. Date signed (Month, Day, Year) 8/2/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JIM PARSHALL 9000 FRANKLIN SQUARE DR., BALTIMORE, MD.									
31. Date filed (Month, Day, Year) AUG 06 1996			32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23215

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Timothy M. McKinney

2. Date of Death

Month Day Year
Aug. 03 1996

3. Time of Death

11:05 AM

4a. Facility Name (If not Institution, give street and number)

6213 Ebenezer Rd.

4b. City, Town, or Location of Death

Essex

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-02-1935

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

17 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 2, 1979

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6213 Ebenezer Road

10f. Zip Code

21220

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Crew Chief

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Darrell McKinney

18. Mother's Name (First, Middle, Maiden Surname)

Patricia Thomas

19a. Informant's Name/Relationship (Type, Print)

Patricia McKinney (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6213 Ebenezer Road, Baltimore, Maryland 21220

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Holly Hill Memorial Park 8-7-96

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home

9705 Belair Road, Baltimore, Maryland 21236

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. Hanging
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb.
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☒ Suicide 6 ☐ Could not be
4 ☐ Homicide determined28a. Date of Injury
(Month, Day Year)

Found 8/13/96

28b. Time of
Injury

0745 AM

28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject hanged self

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

shed at home

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

Essex, Maryland 6213 Ebenezer Road

29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

Aug. 4, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Theodor M. King 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 06 1996

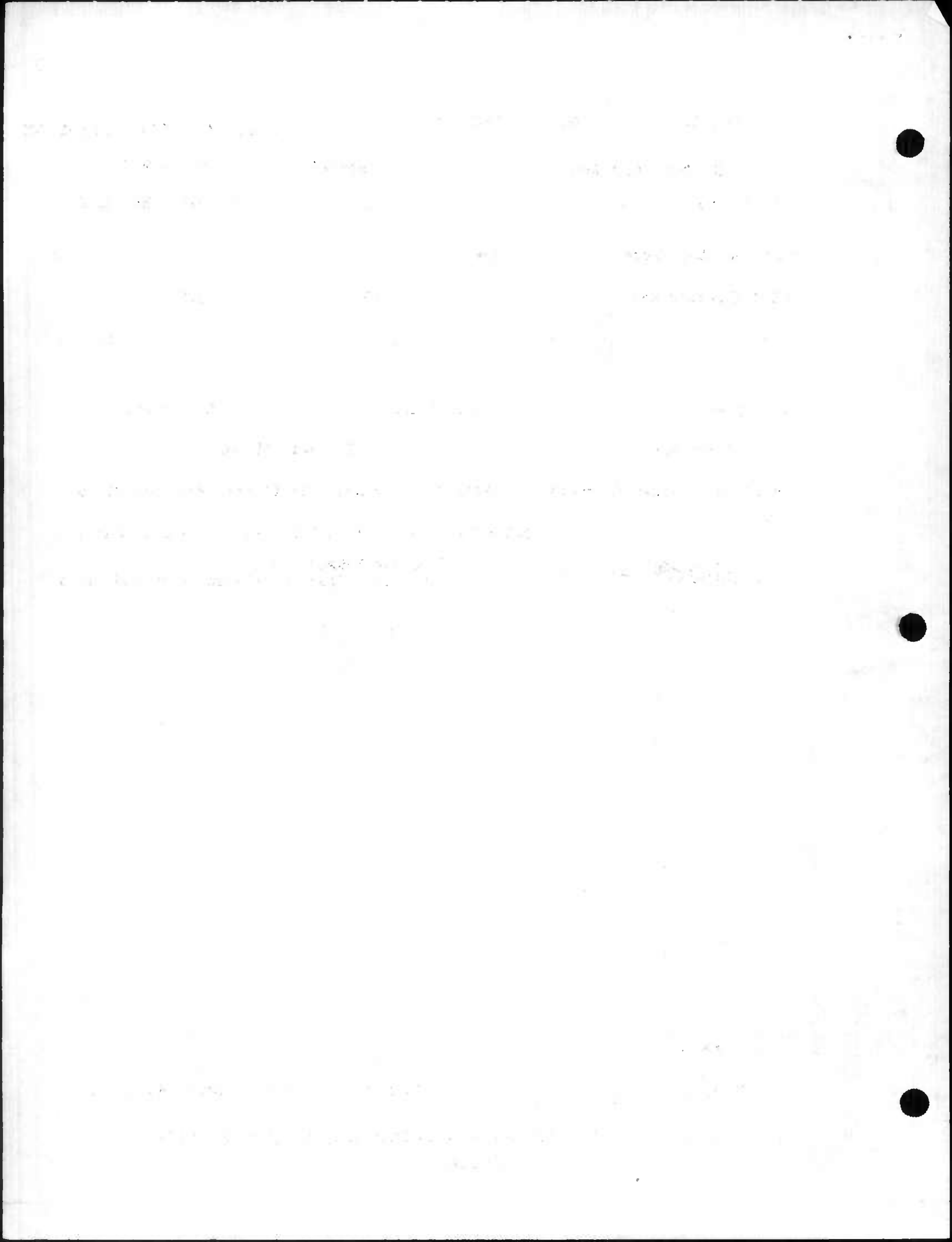
32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23216

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Vincent Francis Maranto III				2. Date of Death Month Day Year August 4, 1996		3. Time of Death 4:46 A.M.	
	4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital				4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A	
Funeral Director	5. Social Security Number 218-14-5151		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 14, 1923	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore City	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 3801 Parkmont Avenue		10f. Zip Code 21206		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Unknown		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4 or 5+) 12th Grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic		16b. Kind of Business/Industry Steel Company			
	17. Father's Name (First, Middle, Last) Vincenzo Francis Maranto, II				18. Mother's Name (First, Middle, Maiden Surname) Rose Marie D'Anna			
	19a. Informant's Name/Relationship (Type, Print) Nadine Virginia Maranto -Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3801 Parkmont Avenue, Baltimore, Maryland-21206			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		20c. Location - City or Town, State Baltimore, Maryland		20d. Date 8/7/96	
	21. Signature of Funeral Service Licensee <i>John C. Miller</i>				22. Name and Address of Facility 6415 Belair Road John C. Miller, Inc. Baltimore, Maryland-21206			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Hypertensive Cardiovascular Disease</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Physician /Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <i>David Goldscher M.D.</i>				29c. License number D16770		29d. Date signed (Month, Day, Year) 8/5/96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Goldscher, M.D., 5601 Loch Raven Boulevard, Baltimore, Maryland 21239							
State Registrar	31. Date filed (Month, Day, Year) AUG 06 1996		32. Registrar's Signature <i>John Davidson-Randall</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23217

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES NALLE				2. Date of Death Month Day Year AUG. 1 96		3. Time of Death 4:36 P.M.		
	4e. Facility Name (If not institution, give street and number) MERCY HOSPICE				4b. City, Town, or Location of Death BALTIMORE, CITY		4c. County of Death BALTIMORE, CITY		
Funeral Director	5. Social Security Number 218-46-1448	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 50 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 11/3/1945		9. Birthplace (State or Foreign Country) NEW JERSEY	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County BALTIMORE, CITY	10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 2129 WEST FAYETTE STREET			10f. Zip Code 21223		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FOOD SERVICE WORKER			16b. Kind of Business/Industry SERVICE AMERICA			
	17. Father's Name (First, Middle, Last) MORRIS NALLE				18. Mother's Name (First, Middle, Maiden Surname) BEAUTISSEA TAYLOR				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) CARLETTE NALLE (WIFE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2129 WEST FAYETTE STREET BALTIMORE, MARYLAND 21223				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) WESTERN STAR CEMETERY		Date 8/6/1996		20c. Location - City or Town, State CATONSVILLE, MARYLAND		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME PA. 1300 EUTAW PLACE BALTIMORE, MARYLAND 21217				
	23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest.								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
23c. Immediate Cause (Final disease or condition resulting in death) a. LUNG CANCER Due to (or as a consequence of):									
23d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) STELLA MARIS AT MERCY					
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA				Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number D40480		29d. Date signed (Month, Day, Year) August 2, 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FERNANDO J. FERNAD MD 5810 BERATA RD BALTO, MD 21206									
31. Date filed (Month, Day, Year) AUG 06 1996				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

96 23218

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Willie Belle Parron</i>				2. DATE OF DEATH MONTH DAY YEAR <i>August-5-1996</i>		3. TIME OF DEATH <i>0430</i>	
4. SOCIAL SECURITY NUMBER <i>216-28-6787</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>86</i> YRS.		7. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 29, 1912</i>	
8. FACILITY NAME (If not institution, give street and number) <i>St. Elizabeth Nursing Home</i>				9. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		10. COUNTY OF DEATH <i>N/A</i>	
11. STATE <i>Maryland</i>		12. COUNTY <i>N/A</i>		13. CITY, TOWN OR LOCATION <i>Baltimore</i>		14. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
15. STREET AND NUMBER <i>2809 Mohawk Ave.</i>				16. ZIP CODE <i>21207</i>		17. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
18. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		19. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		21. RACE — American Indian, Black, White, etc. Specify: <i>Negro</i>	
22. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6</i> College (1-4 or 5+) <i>0</i>		23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Domestic</i>		24. KIND OF BUSINESS/INDUSTRY <i>Outside Home</i>			
25. FATHER'S NAME (First, Middle, Last) <i>Harges Johnson</i>				26. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Lavinia Johnson</i>			
27. INFORMANT'S NAME (Type/Print) <i>Mr. Wilbur Hicks</i>				28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2809 Mohawk Ave. Balto. Md. 21207</i>			
29. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Western Star 8/9/96</i>		31. LOCATION — City or Town, State <i>Catonsville, Md.</i>			
32. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph L. Russ</i>				33. NAME AND ADDRESS OF FACILITY <i>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Squamous cell carcinoma of the lung.</i> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic obstructive lung disease</i>							
34. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		35. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
36. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		37. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
38. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		39. DATE OF INJURY (Month, Day, Year)		40. TIME OF INJURY M <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		41. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
42. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				43. DESCRIBE HOW INJURY OCCURRED			
44. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		45. SIGNATURE AND TITLE OF CERTIFIER <i>Kris E. Kuhn, M.D.</i>					
46. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>KRIS E. KUHN, M.D.</i>		47. LICENSE NUMBER <i>D 37464</i>		48. DATE SIGNED (Month, Day, Year) <i>August 5, 1996</i>			
49. DATE FILED (Month, Day, Year) <i>AUG 06 1996</i>		50. REGISTRAR'S SIGNATURE					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

8/6/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23219

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

YASHIN CAPRESE RIVERS

2. Date of Death

Month Day Year
Aug. 03 1996

3. Time of Death

11:30 AM

4e. Facility Name (If not institution, give street and number)

Sinai Hospital E.R

4b. City, Town, or Location of Death

Balto. City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

219-45-4415

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
June 15, 1995

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State
Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5311 Cuthbert Ave.

10f. Zip Code

21225

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Negro

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Antoine Rivers

18. Mother's Name (First, Middle, Maiden Surname)

Denise Byer

19a. Informant's Name/Relationship (Type, Print)

Mrs. Elizabeth Rivers

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

312 Elizabeth Ave. Balto. Md. 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion (Babylonia)

Date

8/8/96

20c. Location - City or Town, State

Lansdowne, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

BRONCHIOLITIS

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Theodore M. King

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

Aug. 4, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 06 1996

32. Registrar's Signature

John Davidson Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23220
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HAROLD WILLIAM RIECKE				2. Date of Death 8/4/96 Month Day Year AUGUST 21 1996		3. Time of Death 10 PM	
	4a. Facility Name (If not institution, give street and number) 1 SUMMIT AVE.				4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 214-01-7111		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) 6/21/1912	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location GLEN BURNIE	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1 SUMMIT AVE.		10f. Zip Code 21060		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) NONE		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LITHOGRAPHER		16b. Kind of Business/Industry METAL PRINTING COMPANY			
	17. Father's Name (First, Middle, Last) WILLIAM RIECKE				18. Mother's Name (First, Middle, Maiden Surname) MARY SPENCER			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) GERTRUDE W. RIECKE (WIFE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 SUMMIT AVE., GLEN BURNIE, MD 21060			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK		20c. Date 8/8/96		20d. Location - City or Town, State GLEN BURNIE	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	21. Signature of Funeral Service Licensed 				22. Name and Address of Facility SINGLETON FUNERAL HOME 1 SECOND AVE. S.W., GLEN BURNIE, MD 21061			
	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Adenocarcinoma Primary Due to (or as a consequence of): b. Emphysema Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 3 weeks 6 months			
State Registrar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)		29b. Signature and title of certifier 		29c. License number D20094		29d. Date signed (Month, Day, Year) 08/05/96	
30. Name and address of person who completed cause of death (Item 28a) (Type, Print) 2855 Oakwood Rd, Glen Burnie, Md, 21061		31. Date filed (Month, Day, Year) AUG 06 1996						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23221

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Emmy Raymond				2. Date of Death Month 07 Day 31 Year 96		3. Time of Death 5:47am		
	4a. Facility Name (If not institution, give street and number) Mercy Hospital				4b. City, Town, or Location of Death Baltimore, MD		4c. County of Death Baltimore City		
Funeral Director	5. Social Security Number 217 18 1191		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) 6/12/16		
	10a. State md		10b. County N.A.		10c. City, Town or Location Balto		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (14 or 5+) College				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian		16b. Kind of Business/Industry Balto. School			
17. Father's Name (First, Middle, Last) Nathaniel Raymond				18. Mother's Name (First, Middle, Maiden Surname) MILLIE PARREN					
19a. Informant's Name/Relationship (Type, Print) ARLENE RAYMOND. DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 911 E. CHASE ST BALTO. MD. 21202					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MT-ZION Cem.		Date 8/5/96		20c. Location - City or Town, State Landsdowne, Md	
21. Signature of Funeral Service Licensee Joseph B. Locks, Jr				22. Name and Address of Facility Locks Funeral Home 1304 N. Central Ave					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Pulmonary Hypoxemia Due to (or as a consequence of): b. Pulmonary Hypertension Due to (or as a consequence of): c. Interstitial Lung Disease Due to (or as a consequence of): d. Chronic Obstructive Pulmonary Disease									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Bowel Ischemia Diverticulitis									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Bilal Hussain, M.D.				29c. License number P08670		29d. Date signed (Month, Day, Year) July 31, 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BILAL HUSSAIN, M.D., UNIV. OF MD HOSP., 22 S. GREENE ST., BALTO., MD. 21201									
31. Date filed (Month, Day, Year) AUG 06 1996				32. Registrar's Signature Davidson-Randall					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23222

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Hilda Ruth Shackelford				2. Date of Death Month August Day 5 Year 1996		3. Time of Death 1:05p.m.	
	4a. Facility Name (If not institution, give street and number) North West Hospital Center				4b. City, Town, or Location of Death Randallstown		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 220-74-7569		6. Sex 1 M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 6, 1923	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Lansdowne			10d. Inside City Limits 1 Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 2223 Hammonds Ferry Road				10f. Zip Code 21227		10g. Citizen of What Country? United States		
11. Marital Status 1 Never Married 2 Married 3 <input checked="" type="checkbox"/> Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Caucasian	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 rd. College (1-4 or 5+) ---				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Home	
17. Father's Name (First, Middle, Last) Samuel Bearers				18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth Schaffer				
19a. Informant's Name/Relationship (Type, Print) Zella Scholl				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2223 Hammond Ferry Rd Lansdowne, MD 21227				
20a. Method of Disposition 1 Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fork U. Methodist Ch. Cem		Date 08/08/1996		20c. Location - City or Town, State Fork, Maryland		
21. Signature of Funeral Service Licensee <i>Joseph J. W. Kellner</i>				22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Rd Randallstown, MD 21133-4784				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerosis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								Approximate interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular accident Hypertension								23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner? 1 Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 Residence 6 Other (Specify)				
27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Joe H. Ginsberg</i>		29c. License number D20964		29d. Date signed (Month, Day, Year) August 6, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jerome H. Ginsberg, M.D. 8630 Liberty Plaza Mall Randallstown, MD 21133								
31. Date filed (Month, Day, Year) AUG 06 1996				32. Registrar's Signature <i>Julia Anderson-Randall</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23223

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Irma Marie Sanford

2. Date of Death

Month Day Year
August 4, 1996

3. Time of Death

11:15 a.m.

4a. Facility Name (If not institution, give street and number)

Caton Manor Nursing Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

--

Funeral
Director

5. Social Security Number

214-38-8559

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 20, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland

10b. County

--

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3616 Clarenell Road

10f. Zip Code

21229

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4 or 5+)

--

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Arthur

Lehmann

18. Mother's Name (First, Middle, Maiden Surname)

Minna

Carstens

19a. Informant's Name/Relationship (Type, Print)

Gary P. Sanford, Sr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3616 Clarenell Road Baltimore, Maryland 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Pauls Lutheran

Date

August 7, 1996 Baltimore, Maryland

21. Signature of Funeral Service Licensee

Joseph J. W. Kellner

22. Name and Address of Facility

Loring Byers Funeral Directors, Inc.

8728 Liberty Rd Randallstown, MD 21133-4784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Congestive Heart Failure

Due to (or as a consequence of):

Previous Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1 Day

2 Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W. L. Hines M.D. Attending Doctor

29c. License number

D21684

29d. Date signed (Month, Day, Year)

8-5-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. V. CYRIAC M.D. 1600 CRAIN HWY #106 GLEN BURNIE, MD 21061

31. Date filed (Month, Day, Year)

AUG 06 1996

32. Registrar's Signature

John Andrew Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ITEM: 1. PER FH.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

4a, 4b, PER DR. FILM G-738

State of Maryland / Department of Health and Mental Hygiene

96 23224

8/6/96 t.t

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RICHARD CHARLES SWANHART <i>RICHARD C. SWANHART</i>		2. Date of Death Month JULY Day 30 Year 1996		3. Time of Death 19:40
	4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER 211 HICKORY POINT ROAD		4b. City, Town, or Location of Death ANNAPOLIS PASADENA		4c. County of Death ANNE ARUNDEL
Funeral Director	5. Social Security Number 190-28-0090	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) 10-15-1935		9. Birthplace (State or Foreign Country) PENNSYLVANIA		
Usual Residence of Decedent					
10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location PASADENA	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 211 HICKORY POINT ROAD			10f. Zip Code 21122		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1958 If Yes, Give Year or Dates: 1959		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: WHITE					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ENGINEER		16b. Kind of Business/Industry ELECTRONICS	
17. Father's Name (First, Middle, Last) E. GORDON SWANHART			18. Mother's Name (First, Middle, Maiden Surname) MILDRED CONRAD		
19a. Informant's Name/Relationship (Type, Print) M. CAROLE SWANHART (WIFE)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 HICKORY POINT ROAD, PASADENA, MD. 21122		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARKS/3/96		20c. Location - City or Town, State GLEN BURNIE, MD.	
21. Signature of Funeral Service Licensee <i>Valerie Armstrong</i>			22. Name and Address of Facility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061		
23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Metastatic Sarcoma Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					Approximate Interval Between Onset and Death 32 months
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred	
		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>E. W. Cole III</i>		29c. License number D16354		29d. Date signed (Month, Day, Year) 7/31/96	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Enser W. Cole III 900 Bestgate Rd Annapolis, MD 21401					
31. Date filed (Month, Day, Year) AUG 06 1996		32. Registrar's Signature <i>Julia Anderson-Randall</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

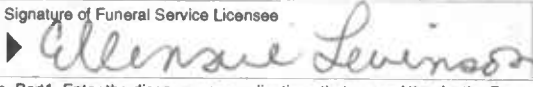
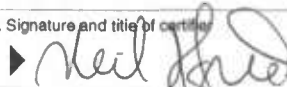
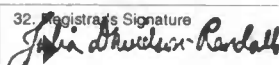
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEMS: 1. & 10g, PER F.H. FILM / State of Maryland / Department of Health and Mental Hygiene 96 23225
G-738 8/6/96 t.t. Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ILYA ILIA SHPILMAN				2. Date of Death Month JULY Day 31 Year 1996		3. Time of Death 8am	
	4a. Facility Name (If not institution, give street and number) 7603 LORRY LANE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 219-37-2685		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 22 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUNE 8, 1974	9. Birthplace (State or Foreign Country) UKRAINE
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 7603 LORRY LANE				10f. Zip Code 21208		10g. Citizen of What Country? USA UKRAINE	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STUDENT		16b. Kind of Business/Industry SCHOOL			
	17. Father's Name (First, Middle, Last) IYSYP SHPILMAN				18. Mother's Name (First, Middle, Maiden Surname) ANNA ZAIKOVATAIA			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) MR. IYSYP SHPILMAN (FATHER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7603 LORRY LANE BALTIMORE, MD 21208			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHEVRA AHAVAS CHESED		Date - 8-1-1996		20c. Location - City or Town, State RANDALLSTOWN, MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Sol Levinson & Bros., Inc. 8900 Reisterstown Road Pikesville, MD 21208			
	23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hepatocellular Carcinoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 3 1/3 years							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 				29c. License number 042178		29d. Date signed (Month, Day, Year) 7/31/96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neil S. Friedman 2435 W. Boulevard Str. 23 Balto, MD 21245							
31. Date filed (Month, Day, Year) AUG 06 1996		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23226

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy J. Sheehan				2. Date of Death Month Day Year July 23 1996				3. Time of Death 8:00 pm						
	4a. Facility Name (If not Institution, give street and number) Collingswood Nursing Home				4b. City, Town, or Location of Death Rockville				4c. County of Death Montgomery						
Funeral Director	5. Social Security Number 502-12-4257		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 22, 1924		9. Birthplace (State or Foreign Country) Minnesota						
	Usual Residence of Decedent														
10a. State Md.		10b. County Montgomery		10c. City, Town or Location Rockville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
10e. Street and Number 299 Hurley Avenue				10f. Zip Code 20852			10g. Citizen of What Country? USA								
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Social Worker				16b. Kind of Business/Industry Fairfax County							
17. Father's Name (First, Middle, Last) John Walter Johnson				18. Mother's Name (First, Middle, Maiden Surname) Agnes McDonnell											
19a. Informant's Name/Relationship (Type, Print) Mark Sheehan/Ex-Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6003 Lux Lane Rockville Md. 20852											
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Lebanon		Date 7/26/96		20c. Location - City or Town, State Adelphi. Md.								
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ives-Pearson Funeral Homes Falls Church, Va. 22046											
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIO PULMONARY ARREST Due to (or as a consequence of): b. DIABETES INSIPIDUS Due to (or as a consequence of): c. NORMAL PRESSURE HYDROCEPHALUS Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA, BIPOLAR DISORDER, URINARY TRACT INFECTION										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred					
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier 		29c. License number D26571		29d. Date signed (Month, Day, Year) 7/25/96	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IRVING MIZUS, MD 4930 DEL RAY AVE. BETHESDA, MD 20814															
31. Date filed (Month, Day, Year) AUG 06 1996				32. Registrar's Signature 											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23227

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Orpha E. SEYMOUR

2. Date of Death

August 2, 1996 Year

3. Time of Death

12:50am

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rossville

4c. County of Death

Baltimore County

Funeral
Director

5. Social Security Number

227-40-2417

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 24, 1922

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1020 Old Eastern Avenue

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collage (1-4or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

James Benson

18. Mother's Name (First, Middle, Maiden Surname)

Lillie Mae Carter

19a. Informant's Name/Relationship (Type, Print)

Betty Cochran (SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1020 Old Eastern Avenue Essex, Md. 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Mem. Gardens

Date

8/5/1996

20c. Location - City or Town, State

Baltimore Co., Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Brudzinski Funeral Home P.A.

1407 Old Eastern Avenue Essex, Md. 21221

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Emphysema

Approximate Interval Between Onset and Death

10 Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lung Cancer

Gastrointestinal Bleeding

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

025717

29d. Date signed (Month, Day, Year)

August 2, 1996

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Stephen Selinger, M.D., 9000 Franklin Square Drive Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

AUG 06 1996

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALBERT SAUNDERS		2. Date of Death Month AUG. Day 01 , Year 1996		3. Time of Death 10:47 PM	
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death n/a	
Funeral Director	5. Social Security Number 214-64-4186		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 39 Yrs.	
	8. Date of Birth Month JUL. Day 25 , Year 1957		9. Birthplace (State or Foreign Country) BALTIMORE, MD			
To Be Completed by Funeral Director	Usual Residence of Decedent					
	10a. State MD		10b. County n/a		10c. City, Town or Location BALTIMORE	
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
	10e. Street and Number 939 ABBOTT COURT		10f. Zip Code 21202		10g. Citizen of What Country? UNITED STATES	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: BLACK					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) - College (1-4 or 5+) 2 years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER		16b. Kind of Business/Industry unemployed	
	17. Father's Name (First, Middle, Last) AARON SAUNDERS		18. Mother's Name (First, Middle, Maiden Surname) THELMA FITZGERALD			
	19e. Informant's Name/Relationship (Type, Print) SHARON SAUNDERS		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1237 ELMLEAF COURT., BALTIMORE, MD 21202			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) VOSHELL MEMORIAL GARDENS		20c. Location - City or Town, State 8-7 DUNDALK, MD	
21. Signature of Funeral Service Licensee <i>D. Valencia Holland</i>		22. Name and Address of Facility WM. C. MARCHFH.-1101 E. NORTH AVENUE				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot wounds Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					Approximate interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 8-1-96		28b. Time of Injury 1009 AM	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject was shot			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street		28f. Location (Street and Number or Rural Route Number, City or Town, State) 1300 E. Lanvale Street Baltimore City, Maryland			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
	29b. Signature and title of certifier <i>D. Valencia Holland</i>		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) AUG. 02, 1996	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. LARON WOLFE, MD 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) AUG 06 1996		32. Registrar's Signature <i>Davidson-Randall</i>				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23229

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) AARON THOMAS III				2. Date of Death Month Day Year 08 01 96		3. Time of Death 8:00 AM	
	4a. Facility Name (If not institution, give street and number) 5834 JONQUIL AVENUE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA	
Funeral Director	5. Social Security Number 215-60-4975		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 42 Yrs.		8. Date of Birth (Month, Day, Year) 2-6-1954	
	10a. State MD		10b. County NA		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	Usual Residence of Decedent				10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) 2 yrs		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Environmental Inspector		16b. Kind of Business/Industry City of Baltimore			
	17. Father's Name (First, Middle, Last) Aaron Thomas, Jr.				18. Mother's Name (First, Middle, Maiden Surname) Eva D. Eastley			
	19a. Informant's Name/Relationship (Type, Print) Eva D. Thomas - Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5834 Jonquil Avenue Balto, MD 21215			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park		20c. Location - City or Town, State 8-6-96 Randallstown, MD		20d. Date	
	21. Signature of Funeral Service Licensee Glenn B. Harris				22. Name and Address of Facility Marjorie H. West 21215 4300 Walbrook Avenue Balto, MD			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. metastatic colon cancer. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier Eric Fisher MD				29c. License number D25331		29d. Date signed (Month, Day, Year) 8/1/96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric Fisher 101 W. Read Street Balto, MD 21201							
31. Date filed (Month, Day, Year) AUG 06 1996				32. Registrar's Signature John Buckner-Randall				

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

ITEM#26 g738 8/12/96ag perDr.
ITEM: 4. PER F.H. FILM G-738 8/6/96 t.t

96 23230

FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) CLARENCE W. TRAYNHAM				2. DATE OF DEATH MONTH DAY YEAR August 1, 1996		3. TIME OF DEATH 6:04 P M	
4. SOCIAL SECURITY NUMBER 214-20-1897		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-16-1926	
9a. FACILITY NAME (If not institution, give street and number) Mercy Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A	
10a. STATE Md				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 2909 Westwood Avenue			
10f. ZIP CODE 21216				10g. CITIZEN OF WHAT COUNTRY? U S A			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Feeder		16. KIND OF BUSINESS/INDUSTRY Bethlehem Steel			
17. FATHER'S NAME (First, Middle, Last) Charlie Traynham				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillie Botts			
19a. INFORMANT'S NAME (Type/Print) Herman Traynham				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2909 Westwood Avenue Baltimore, Md 21216			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cemetery 8-6-96		20c. LOCATION — City or Town, State Baltimore, Md		20d. DATE 8-6-96	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bladys Wanner				22. NAME AND ADDRESS OF FACILITY March F/H West 21215 4300 Wabash Avenue Baltimore, Md			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Prostate Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 3 yrs.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. DATE SIGNED (Month, Day, Year) 8/2/96			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Kendall R Faulkner		29c. LICENSE NUMBER D05643		29d. DATE SIGNED (Month, Day, Year) 8/2/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD. TOWSON, MD 21204							
31. DATE FILED (Month, Day, Year) AUG 06 1996		32. REGISTRAR'S SIGNATURE John Andrew Randall					

96-4306-025

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AM ITEMS: 23 PART I, 27, 28a-f, State of Maryland / Department of Health and Mental Hygiene

96 23231

PER MEO FILM g-738 8/15/96 t.t

Certificate of Death

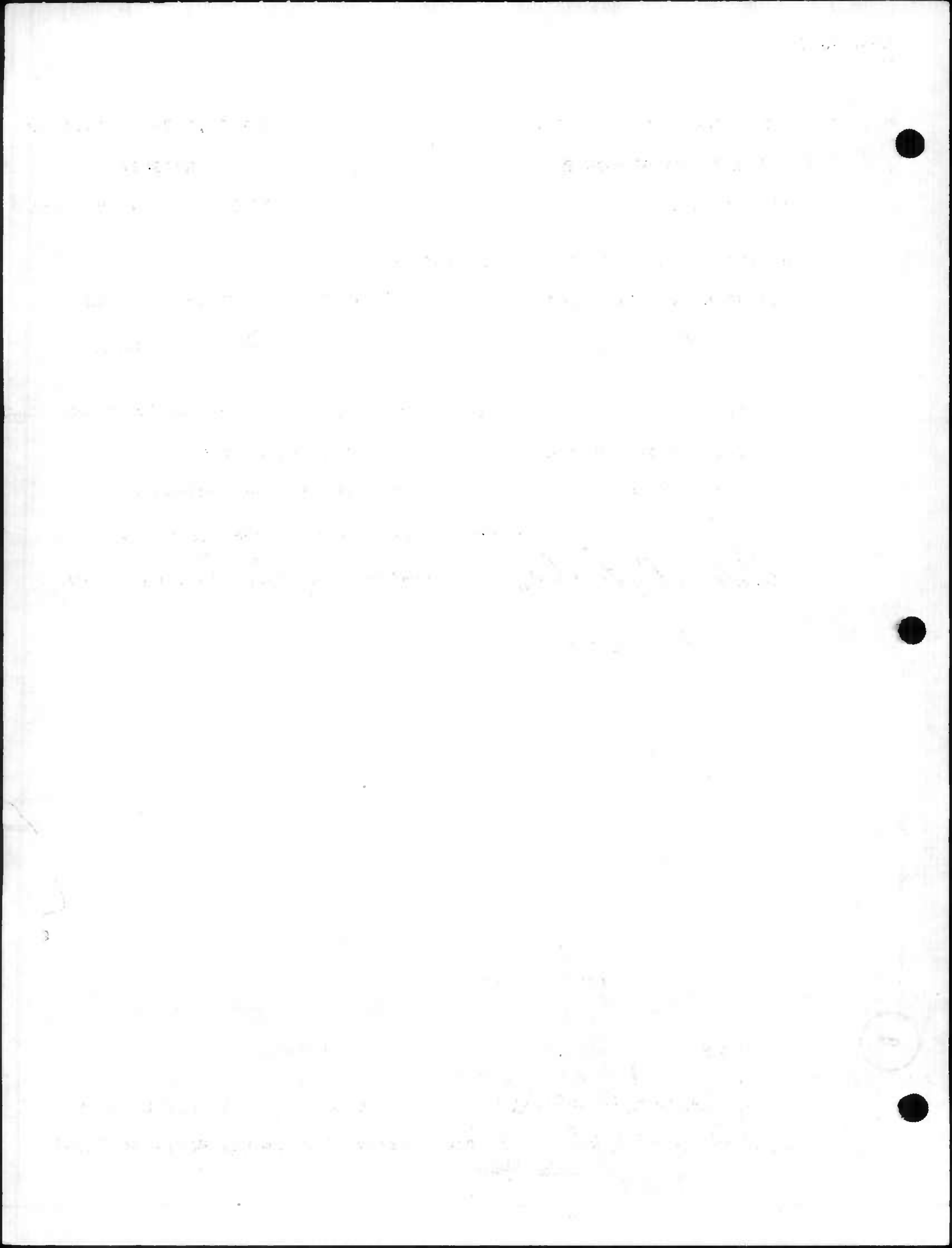
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RAYMOND EMROSE THOMAS				2. Date of Death Month Day Year JULY 31, 1996		3. Time of Death 14:40 P	
	4a. Facility Name (If not institution, give street and number) 829 WHEELER SCHOOL RD.				4b. City, Town, or Location of Death WHITEFORD		4c. County of Death HARFORD	
Funeral Director	5. Social Security Number 236-84-3843		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 43 Yrs.		8. Date of Birth (Month, Day, Year) 12/30/52	
	9. Birthplace (State or Foreign Country) West Virginia		10a. State Maryland		10b. County Harford		10c. City, Town or Location Whiteford	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 829 Wheeler School Road		10f. Zip Code 21160		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpet Mechanic		16b. Kind of Business/Industry Floor Coverings			
	17. Father's Name (First, Middle, Last) Charles Wesley Thomas				18. Mother's Name (First, Middle, Maiden Surname) Katherine Smith			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Susan E. Thomas				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 826 Wheeler School Road Whiteford, MD			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Yorktowne Crematory		20c. Location - City or Town, State 8/2/96 York, PA		21. Signature of Funeral Service Licensee <i>Jeffrey P. Lovelidge</i>	
To Be Completed by Physician/Medical Examiner	22. Name and Address of Facility Harkins Funeral Home, Inc. Delta, PA				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. CONTACT GUNSHOT WOUND OF HEAD Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):			
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined			
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day Year) 7-31-96				28b. Time of Injury UNKNOWN M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how Injury occurred SUBJECT FOUND SHOT				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) HOME			
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State) 829 WHEELER SCHOOL RD. WHITEFORD, MD.				29a. Certifier (Check one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
	29b. Signature and title of certifier <i>James L. Locke MD</i>				29c. License number OCME		29d. Date signed (Month, Day, Year) AUGUST 01, 1996	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201				31. Date filed (Month, Day, Year) AUG 06 1996			
	32. Registrar's Signature <i>James L. Locke</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

20



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23232

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALPHONSO WILSON				2. Date of Death Month Day Year AUGUST 4, 1996		3. Time of Death 5:00 am												
	4a. Facility Name (If not institution, give street and number) 4565 THE STRAND				4b. City, Town, or Location of Death Balto		4c. County of Death NIA												
Funeral Director	5. Social Security Number 248-56-4725	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb 16, 1934		9. Birthplace (State or Foreign Country) SC.											
	Usual Residence of Decedent																		
To Be Completed by Funeral Director	10a. State md	10b. County NIA	10c. City, Town or Location Balto			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No													
	10e. Street and Number 4565 The Strand			10f. Zip Code 21215		10g. Citizen of What Country? U.S.A													
	11. Marital Status 1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black												
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10- NIA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeping			16b. Kind of Business/Industry Broadway Services													
	17. Father's Name (First, Middle, Last) Albert Wilson				18. Mother's Name (First, Middle, Maiden Surname) Eliza Ellerbe														
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Margarine Bethea - Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4565 The Strand Balto, md 21215														
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem Pl		20c. Location - City or Town, State 8/2/96 Balto, md														
	21. Signature of Funeral Service Licensee Gladys Wane				22. Name and Address of Facility MARCH FH. - 4300 WABASH AVENUE, BALTIMORE, MD														
	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>e. Resp. Arrest</td> <td rowspan="4">Approximate interval Between Onset and Death</td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b. Metastatic Colon Cancer</td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c. Hepatic Failure</td> <td rowspan="4">3 mos</td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> </tr> <tr> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	e. Resp. Arrest	Approximate interval Between Onset and Death	Due to (or as a consequence of):	b. Metastatic Colon Cancer	Due to (or as a consequence of):	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Hepatic Failure	3 mos	Due to (or as a consequence of):	d.
Immediate Cause (Final disease or condition resulting in death)	e. Resp. Arrest	Approximate interval Between Onset and Death																	
	Due to (or as a consequence of):																		
	b. Metastatic Colon Cancer																		
	Due to (or as a consequence of):																		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Hepatic Failure	3 mos																	
	Due to (or as a consequence of):																		
	d.																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown													
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No													
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No													
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																			
29b. Signature and title of certifier Rebecca R Parry, MD				29c. License number D47844		29d. Date signed (Month, Day, Year) 8/6/96													
30. Name and address of person who completed cause of death (item 23e) (Type, Print) Rebecca R Parry, MD 1000 E Egan St Baltimore, MD 21202																			
31. Date filed (Month, Day, Year) AUG 06 1996				32. Registrar's Signature John A. ...															

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEMS: 23 PART I, 27, PER MEO FIL State of Maryland / Department of Health and Mental Hygiene 96 23233
G-738 8/15/96 t.t. Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JESSE WOODROW WRIGHT

2. Date of Death

Month Day Year
JULY 29, 1996

3. Time of Death

15:40 P

4a. Facility Name (If not institution, give street and number)

5816 66th. AVE.

4b. City, Town, or Location of Death

Riverdale

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

216-68-0235

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

38 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
12-23-57

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Riverdale

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5816 67th Avenue

10f. Zip Code

20737

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrical Repairman

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Jesse Anderson Wright

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy I. Hasty

19a. Informant's Name/Relationship (Type, Print)

Jesse A. Wright/Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5816 67th Avenue, Riverdale, Maryland 20737

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

8/3/96

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perentis

22. Name and Address of Facility

J. B. Jenkins Funeral Home
7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

FATTY LIVER

Due to (or as a consequence of):

CHRONIC ALCOHOLISM

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dennis J. Chute MD

29c. License number

OCME

29d. Date signed (Month, Day, Year)

JULY 30, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dennis J. Chute MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 06 1996

32. Registrar's Signature

D. Davidson

State
Registrar

Baltimore, Maryland 21215-0020

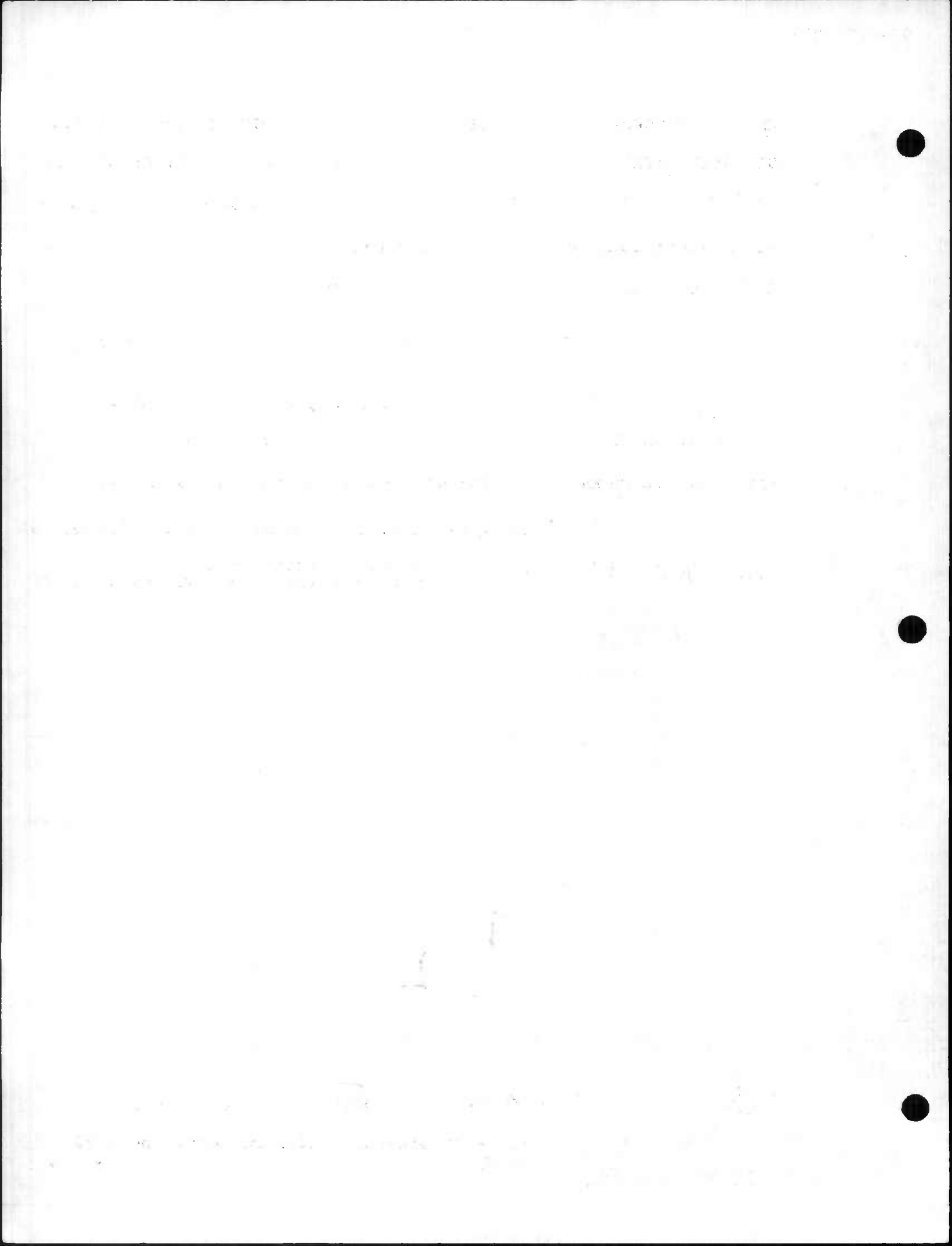
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 23234

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MEYER

WOLFE

2. Date of Death

Month JULY Day 30, Year 1996

3. Time of Death

8:30pm

4a. Facility Name (If not institution, give street and number)

14 POMONA SOUTH, APT. 6

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

212-03-9494

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month MAY Day 7, Year 1912

9. Birthplace (State or Foreign Country)

WEST VIRGINIA

Usual Residence of Decedent

10a. State
MARYLAND10b. County
BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14 POMONA SOUTH, APT. 6

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SALES

16b. Kind of Business/Industry

RESTAURANT SUPPLIES

17. Father's Name (First, Middle, Last)

LOUIS

WOLFE

18. Mother's Name (First, Middle, Maiden Surname)

BESSIE

Patz

19a. Informant's Name/Relationship (Type, Print)

MRS. FLORENCE WOLFE (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14 POMONA SOUTH, APT. 6 BALTIMORE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

OHEB SHALOM MEMORIAL PARK 8-2-1996-REISTERSTOWN, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ellen Levine

22. Name and Address of Facility

Sol Levinson & Bros., Inc.

8900 Reisterstown Road Pikesville, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. COLON CANCER AND LIVER

Due to (or as a consequence of):

3 1/2 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. METASTASES

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D 35606

29d. Date signed (Month, Day, Year)

7/31/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Samuel Ziegler M.D. 210 Crossroads Drive #415 Owings Mills MD

31. Date Filed (Month, Day, Year)

AUG 06 1996

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

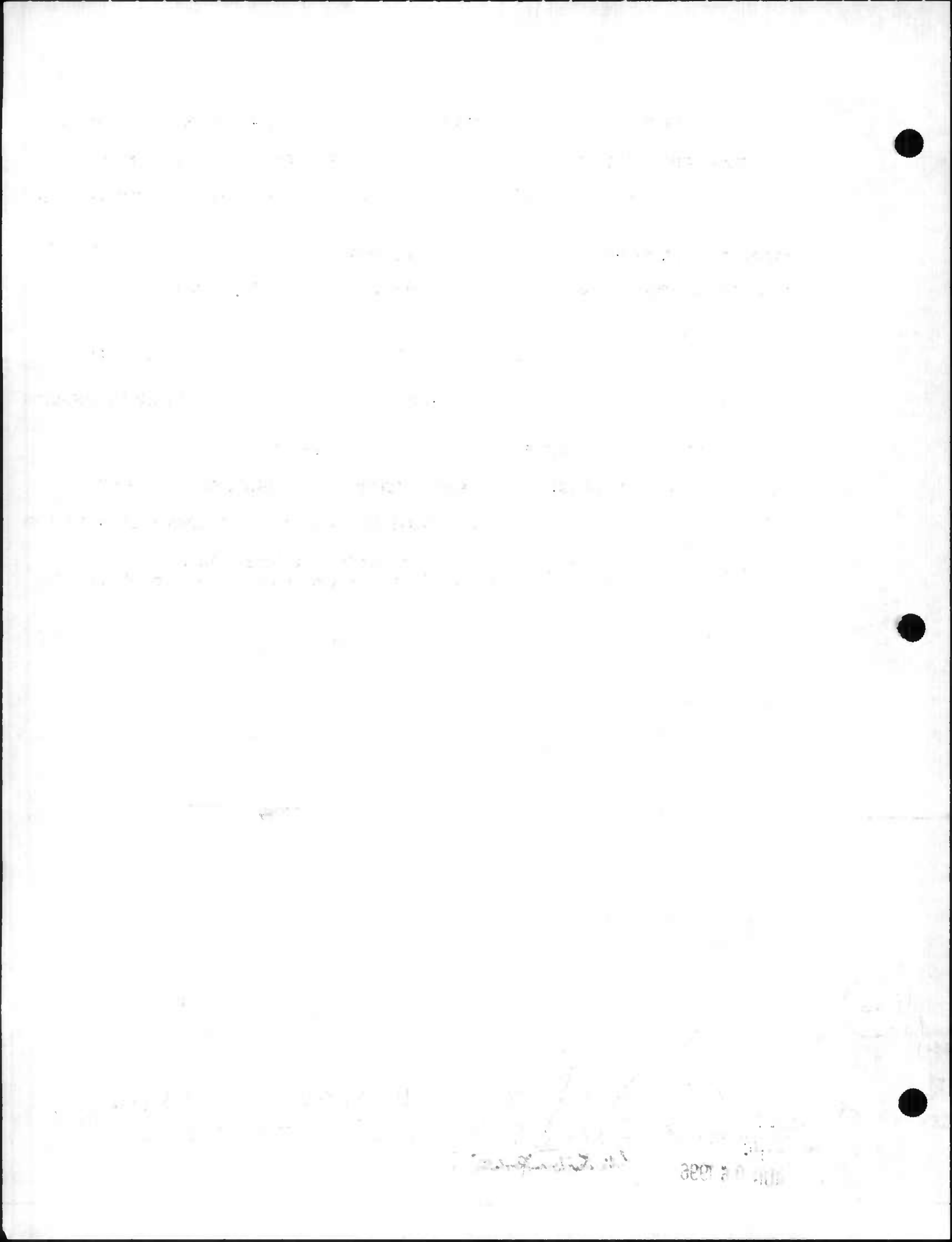
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23235

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KATRINA C. WRIGHT				2. Date of Death Month 7 Day 31 Year 96		3. Time of Death 3:00 AM	
	4a. Facility Name (If not institution, give street and number) 641 BYWATER RD ANNAPOLIS, MD (21401)				4b. City, Town, or Location of Death ANNAPOLIS		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 214-18-7378		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 93 Yrs.		8. Date of Birth (Month, Day, Year) 4 21 03	
	9. Birthplace (State or Foreign Country) MARYLAND		10. Usual Residence of Decedent		11. Decedent's Education (Specify only highest grade completed) 9th		12. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) POLISHER	
To Be Completed by Funeral Director	10a. State MD		10b. County ANNE ARUNDEL		10c. City, Town or Location ANNAPOLIS		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 641 BYWATER ROAD		10f. Zip Code 21401		10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
To Be Completed by Physician/Medical Examiner	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Kind of Business/Industry Tillman Jewelry	
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) POLISHER		17. Father's Name (First, Middle, Last) John W. Chamberg		18. Mother's Name (First, Middle, Maiden Surname) Susie Stepney		19. Informant's Name/Relationship (Type, Print) Alice K. WRIGHT (Daughter)	
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Brewer Cemetery		20c. Location - City or Town, State ANNAPOLIS, Maryland		21. Signature of Funeral Service Licensee Charles E. Hicks II	
	22. Name and Address of Facility House of Hicks F/H 1922 Forest Drive ANNAPOLIS, MD 21401		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aspiration pneumonia Due to (or as a consequence of): b. Repeated Strokes Due to (or as a consequence of): c. IDDM Due to (or as a consequence of): d. HASCVD		Approximate Interval Between Onset and Death 3 Day year		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	29b. Signature and title of certifier Michael J. Lattin		29c. License number D21438		29d. Date signed (Month, Day, Year) 8/2/96		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael J. Lattin MD, 705 Melvin Ave Annapolis Md, 21401	
State Registrar	31. Date filed (Month, Day, Year) AUG 06 1996		32. Registrar's Signature [Signature]		33. Registrar's Title [Signature]		34. Registrar's Office [Signature]	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 23236

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Obie Willingham				2. Date of Death Month Aug. Day 2, Year 1996		3. Time of Death 12:45pm	
	4a. Facility Name (If not institution, give street and number) 7959 Telegraph Road				4b. City, Town, or Location of Death Severn		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 242-34-6802		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Mar. 5, 1929	
	9. Birthplace (State or Foreign Country) North Carolina							
To Be Completed by Funeral Director	10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Severn		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 7959 Tele graph Road				10f. Zip Code 21144		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th		College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Heavy Equipment Repairman		16b. Kind of Business/Industry Industrial	
	17. Father's Name (First, Middle, Last) Obie A. Willingham				18. Mother's Name (First, Middle, Maiden Surname) Ethel Ward			
	19a. Informant's Name/Relationship (Type, Print) Phyllis M. Willingham/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7959 Telegraph Road, Severn, MD 21144			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery		Date 8/5		20c. Location - City or Town, State Brentwood, MD	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Hardesty Funeral Home, P.A. 851 Annapolis Rd, Gambrills, MD 21054			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. METASTATIC CANCER OF HEAD AND NECK Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. N/A							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D36146		29d. Date signed (Month, Day, Year) 8-4-96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KATHERINE TRACZUK, UMCC, 22 SOUTH GREENE ST, BALTIMORE 21201							
	31. Date filed (Month, Day, Year) AUG 06 1996				32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

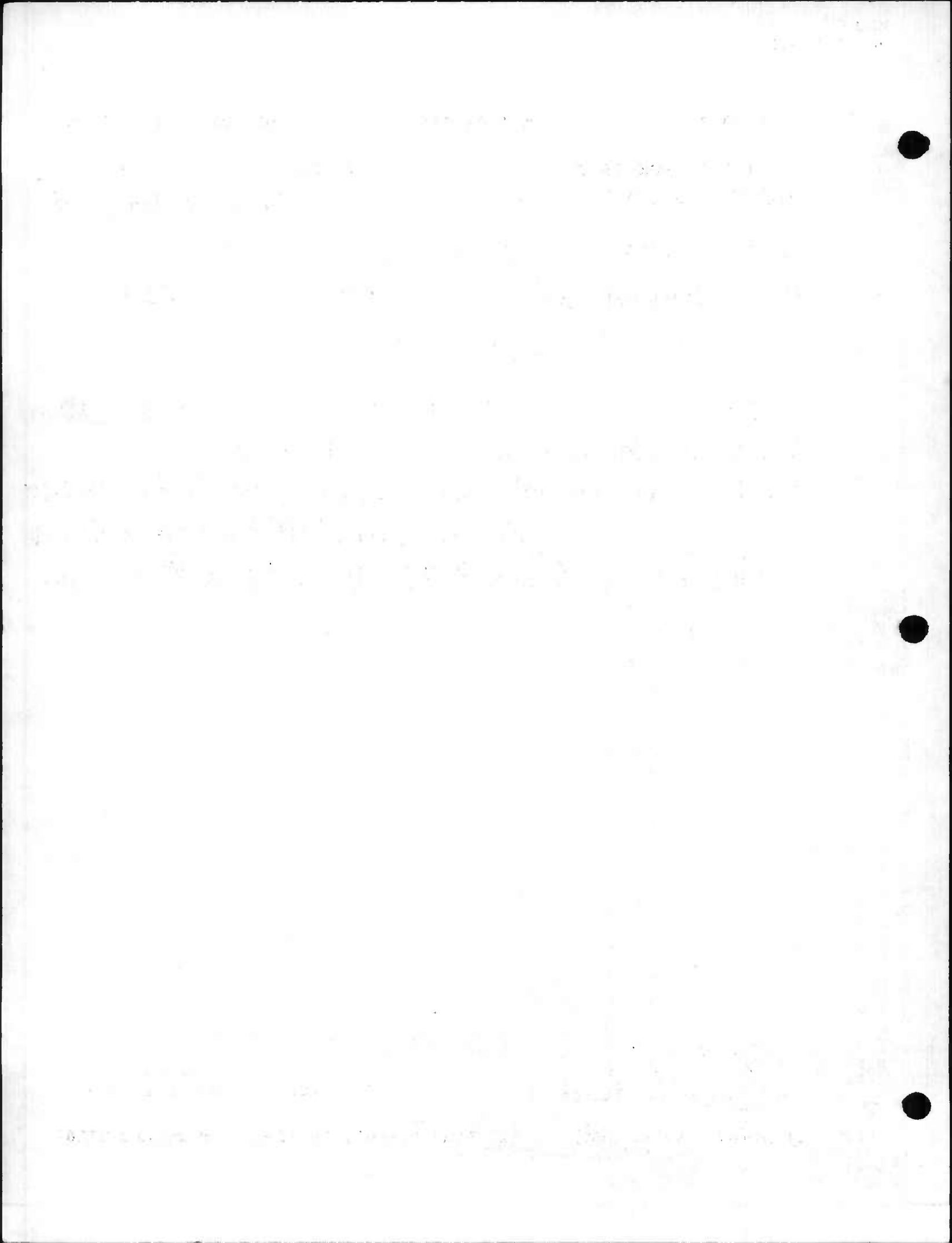
4

State
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HAROLD WAINWRIGHT				2. Date of Death Month Aug. Day 01 Year 1996		3. Time of Death 5:29 PM.			
	4a. Facility Name (If not institution, give street and number) 1121 S. HANOVER ST.				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A			
Funeral Director	5. Social Security Number 214-20-4530		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth Month Jan. Day 16 Year 1927		9. Birthplace (State or Foreign Country) Maryland	
	10a. State Maryland				10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 1121 S. Hanover St.				10f. Zip Code 21230		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Negro			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Transportation			
	17. Father's Name (First, Middle, Last) Leonard Wainwright				18. Mother's Name (First, Middle, Maiden Surname) Clara Bolden					
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Ms. Lisa Wainwright				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 902 Pennsylvania Ave. Apt. 20 Balto Md. 21201					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest		20c. Location - City or Town, State 8/8/96 Owings Mills, Md.					
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Joseph L. Russ				22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sharp force Injuries Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death					
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
					24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 7-31-96		28b. Time of Injury 1015 AM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject was cut	
State Registrar	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier J. LARON LOCKE, MD		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) AUG. 02, 1996			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201				31. Date filed (Month, Day, Year) AUG 06 1996				32. Medical Examiner's Signature J. LARON LOCKE	



Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ESSIE WAINWRIGHT				2. Date of Death Month Day Year AUG. 01, 1996		3. Time of Death 5:29 PM.	
	4a. Facility Name (If not institution, give street and number) 1121 S. HANOVER ST.				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 215-28-1107		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 62 Yrs.		8. Date of Birth Month Day Year March 4, 1934	
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent 10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1121 S. Hanover St.		10f. Zip Code 21230		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Negro	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) Isaiah Gillison	
	18. Mother's Name (First, Middle, Maiden Surname) Mary Lee		19a. Informant's Name/Relationship (Type, Print) Ms. Lisa Wainwright		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 902 Pennsylvania Ave. Apt. 2D Balto. Md. 21201		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
	20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest		20c. Location - City or Town, State 8/8/96 Owings Mills, Md.		21. Signature of Funeral Service Licensee Joseph L. Russ		22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216	
	23a. Pertinent disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sharp force injuries		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 8-31-96	
	28b. Time of Injury 1000 AM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred Subject was cut		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home	
	28f. Location (Street and Number or Rural Route Number, City or Town, State) 1121 S. Hanover Street Baltimore City, Maryland		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Clara Lockhart		29c. License number O.C.M.E.	
	29d. Date signed (Month, Day, Year) AUG. 02, 1996		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VLARON LOCKE, MP 111 Penn Street, Baltimore, Maryland 21201		31. Date filed (Month, Day, Year) AUG 06 1996		32. Registrar's Signature Gina Davidson-Randall	

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23239

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

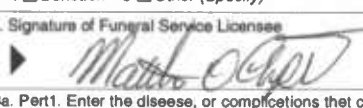
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

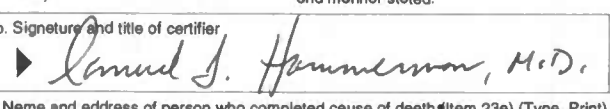

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Louis C. WAYMAN JR.		2. Date of Death Month August Day 2 Year 1996		3. Time of Death 5:45 PM	
4a. Facility Name (If not institution, give street and number) Franklin Square Hospital			4b. City, Town, or Location of Death Rossville		4c. County of Death Baltimore
5. Social Security Number 085-16-7351	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 15, 1923
9. Birthplace (State or Foreign Country) Missouri					
Usual Residence of Decedent					
10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Kingsville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 10006 Gunridge Circle		10f. Zip Code 21087		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 years College (1-4 or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Surety Bond Underwriter		16b. Kind of Business/Industry Finance Company			
17. Father's Name (First, Middle, Last) Louis C. Wayman			18. Mother's Name (First, Middle, Maiden Surname) Mildred Sherman		
19a. Informant's Name/Relationship (Type, Print) Nancy C. Wayman (Wife)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10006 Gunridge Circle, Kingsville, Maryland 21087		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory		20c. Location - City or Town, State 8-5-96 Baltimore, Maryland	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road, Baltimore, Maryland 21236			
23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		e. Hypotension Due to (or as a consequence of):			Approximate Interval Between Onset and Death 4 hours
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Sepsis Due to (or as a consequence of):			24 hours
		c. Bowel infarction Due to (or as a consequence of):			
		d. _____			

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Lymphoma					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number 00050764		29d. Date signed (Month, Day, Year) August 2, 1996	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Samuel Hammerman 9000 Franklin Square Dr. Baltimore, Maryland 21237					
31. Date filed (Month, Day, Year) AUG 06 1996		32. Registrar's Signature 			

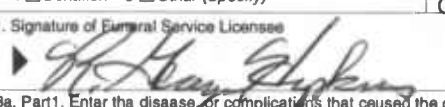
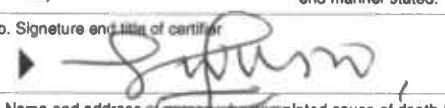
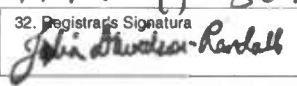
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23240

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HELEN WRIGHT				2. Date of Death Month Day Year AUGUST 3RD 1996				3. Time of Death 3:15 PM										
	4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL Hospital				4b. City, Town, or Location of Death Glen Burnie				4c. County of Death Anne Arundel										
Funeral Director	5. Social Security Number 214-74-5953		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 102 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) 12-15-1893		9. Birthplace (State or Foreign Country) MARYLAND						
	Usual Residence of Decedent				10a. State MARYLAND				10b. County ANNE ARUNDEL				10c. City, Town or Location GLEN BURNIE				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 18 "D" STREET S.W.				10f. Zip Code 21061				10g. Citizen of What Country? U.S.A.											
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER				16b. Kind of Business/Industry OWN HOME											
17. Father's Name (First, Middle, Last) EDWARD REINHARDT				18. Mother's Name (First, Middle, Maiden Surname) MARY HELEN O'NEILL															
19a. Informant's Name/Relationship (Type, Print) HELEN L. LARKIN (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 "D" STREET S.W., GLEN BURNIE, MARYLAND 21061															
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK				Data 8/6/96				20c. Location - City or Town, State GLEN BURNIE, MD 21061							
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SINGLETON FUNERAL HOME 1 SECOND AVE. S.W., GLEN BURNIE, MD 21061															
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Cause (Final disease or condition resulting in death) PNEUMONIA Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death ONE WEEK											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypothyroidism								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown											
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Panding investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)				28b. Time of Injury M				28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No				28d. Describe how Injury occurred			
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier  MD				29c. License number D48006				29d. Date signed (Month, Day, Year) AUGUST 3RD 1996							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOFI OWUSU-BODATEY, 301 HOPP. DR., GLEN BURNIE, MD 21061																			
31. Date filed (Month, Day, Year) AUG 06 1996				32. Registrar's Signature 															

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23241

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET ELIZABETH WATSON

2. Date of Death

Month Day Year
JULY 31, 1996

3. Time of Death

12:17 P.M.

4a. Facility Name (If not institution, give street and number)

12 EUGENIA AVENUE

4b. City, Town, or Location of Death

FERNDAL

4c. County of Death

ANNE ARUNDEL

Funeral
Director

5. Social Security Number

220-22-6319

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
03-19-1920

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

FERNDAL

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12 EUGENIA AVENUE

10f. Zip Code

21061

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8College (1-4 or 5+)
N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

TOLLY

BROWN

18. Mother's Name (First, Middle, Maiden Surname)

MINNIE

MILLER

19a. Informant's Name/Relationship (Type, Print)

SHIRLEY ANN FARRELL (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

927 LANGLER ROAD, GLEN BURNIE, MD. 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GLEN HAVEN MEMORIAL PARK

Data

8/3/96

20c. Location - City or Town, State

GLEN BURNIE, MARYLAND

21. Signature of Funeral Service Licensee

Michael C. Gaffan

22. Name and Address of Facility

SINGLETON FUNERAL HOME,
1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death.

Immediate Cause (Final disease or condition resulting in death)

a. *cholesterol carcinoma*
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*chronic depression**coronary artery disease*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

James Benjamin

29c. License number

D8357

29d. Date signed (Month, Day, Year)

8/1/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. JAMES BENJAMIN, M.D., 479 JUMPERS HOLE ROAD, STE. 304, SEVERNA PARK, MD. 21146

31. Date filed (Month, Day, Year)

AUG 06 1996

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 23242

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARIE Annie ARMSTRONG					2. Date of Death Month Day Year July 26 1996		3. Time of Death 5:30 a.m.	
	4e. Facility Name (If not institution, give street and number) St. Mary's Hospital					4b. City, Town, or Location of Death Leonardtown		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 213-46-8253		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb 27, 1900		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent								
10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Clements				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number Box 358				10f. Zip Code 20624		10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th Grade College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Samuel Thomas					18. Mother's Name (First, Middle, Maiden Surname) Margaret Emily Maddox				
19a. Informant's Name/Relationship (Type, Print) John Henry Armstrong					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 358, Clements, MD 20624				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart Cemetery		Date 7/30/1996		20c. Location - City or Town, State Bushwood, Maryland		
21. Signature of Funeral Service Licensee <i>Michael R. Gardiner</i>					22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>New onset cerebrovascular accident (Stroke)</i> Due to (or as a consequence of): b. <i>Leading to coma</i> Due to (or as a consequence of): c. <i>Death</i> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death <i>~ 24 hrs</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>Kiran M.D.</i>					29c. License number <i>D36206</i>		29d. Date signed (Month, Day, Year) <i>07/16/96</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kiran Mehta M.D. Leonardtown Maryland 20650									
31. Date filed (Month, Day, Year) JUL 30 1996					32. Registrar's Signature <i>John Davidson</i>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



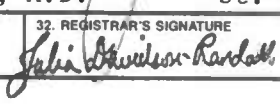
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

96 23243

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) David Troy Anderson				2. DATE OF DEATH MONTH DAY YEAR July 30, 1996		3. TIME OF DEATH 8:35 A. M	
4. SOCIAL SECURITY NUMBER 217-30-1060		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 60 YRS.	7. DATE OF BIRTH (Month, Day, Year) September 11, 1935		8. BIRTHPLACE (State or Foreign Country) Virginia	
9a. FACILITY NAME (If not institution, give street and number) Route 2, Box 107-32				9b. CITY, TOWN OR LOCATION OF DEATH California		9c. COUNTY OF DEATH St. Mary's	
10a. STATE Maryland				10b. COUNTY St. Mary's		10c. CITY, TOWN OR LOCATION California	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER Route 2, Box 107-32				10f. ZIP CODE 20619		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1954-1957		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter		16b. KIND OF BUSINESS/INDUSTRY Construction			
17. FATHER'S NAME (First, Middle, Last) James Anderson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hattie Freeman			
19a. INFORMANT'S NAME (Type/Print) Alma R. Anderson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 2, Box 107-32, California, Maryland 20619			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MD Veterans' Cemetery		DATE 8-1-96		20c. LOCATION — City or Town, State Cheltenham, Maryland	
21. SIGNATURE OF FUNERAL SERVICE PROVIDER  Michael R. Blankenship				22. NAME AND ADDRESS OF FACILITY Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Carcinomatous</i>							
DUE TO (OR AS A CONSEQUENCE OF): <i>Carcinoma of Colon</i>							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  J. Patrick Jarboe, M.D.				29c. LICENSE NUMBER D06419		29d. DATE SIGNED (Month, Day, Year) 7/30/1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Patrick Jarboe, M.D. St. Mary's Medical Arts Bldg., Leonardtown, MD 20650							
31. DATE FILED (Month, Day, Year) JUL 30 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 23244

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARGARET A ALBERTINE				2. DATE OF DEATH MONTH JULY DAY 24 YEAR 1996		3. TIME OF DEATH 0507 A.M.	
4. SOCIAL SECURITY NUMBER 190-32-3392		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 28, 1913	
9a. FACILITY NAME (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH ROCKVILLE		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE PA				10b. COUNTY Luzerne		10c. CITY, TOWN OR LOCATION Hazleton	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 237 W. Muier Avenue				10f. ZIP CODE 18201		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		15b. KIND OF BUSINESS/INDUSTRY None			
17. FATHER'S NAME (First, Middle, Last) Alexander Malik				16. MOTHER'S NAME (First, Middle, Maiden Surname) Theresa Koretz			
19a. INFORMANT'S NAME (Type/Print) Dr. Joseph Albertine (Son)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 239 W. Muier Ave., Hazleton, PA 18201			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Gabriels Cemetery 7/27		20c. LOCATION — City or Town, State Hazleton, PA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George L. Snowden</i>				22. NAME AND ADDRESS OF FACILITY SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis							
DUE TO (OR AS A CONSEQUENCE OF):							
b. Multiple system organ failure 2 days							
c. Pulmonary embolism 1 day							
d. Subdural hematoma 2 weeks							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Encephalopathy							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE NOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Snowden</i>				29c. LICENSE NUMBER D40353		29d. DATE SIGNED (Month, Day, Year) 7/24/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5530 Wisconsin Ave. #1045, Chevy Chase, MD 20815							
31. DATE FILED (Month, Day, Year) JUL 25 1996		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

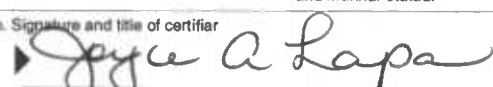
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 23245

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT JASON ALLEN				2. Date of Death Month Day Year JULY 17, 1996				3. Time of Death 07:05 A.M.	
	4a. Facility Name (If not Institution, give street and number) MALCOLM GROW MEDICAL CENTER				4b. City, Town, or Location of Death ANDREWS AFB				4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 463-67-6204		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 24 Yrs.		8. Date of Birth (Month, Day, Year) SEPTEMBER 14, 1971		9. Birthplace (State or Foreign Country) TEXAS	
	Usual Residence of Decedent				10a. State MARYLAND				10b. County PRINCE GEORGES	
To Be Completed by Funeral Director	10c. City, Town or Location ANDREWS AIR FORCE BASE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number BUILDING 1602	
	10f. Zip Code 20762-5000				10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input checked="" type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
To Be Completed by Physician/Medical Examiner	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1990-1996				13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+) AVIATION ELECTRONIC TECHNICIAN U.S. NAVY				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) DENNIS ALLEN				18. Mother's Name (First, Middle, Maiden Surname) SUSAN SIMMONS				19a. Informant's Name/Relationship (Type, Print) SUSAN CURLEE	
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 708 JUDITH, BURLESON, TEXAS 76028				20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) CADDO CEMETERY	
To Be Completed by Physician/Medical Examiner	20c. Location - City or Town, State JOSHUA, TX.				21. Signature of Funeral Service Licensee  MO0091				22. Name and Address of Facility W. W. CHAMBERS CO., RIVERDALE, MD, 20737	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASPHYXIA WHILE ATTEMPTING TO HANG HIMSELF Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year) JULY 17, 1996				28b. Time of Injury M	
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				28d. Describe how Injury occurred SUICIDE BY HANGING				28e. Location (Street and Number or Rural Route Number, City or Town, State) BUILDING 1686 NEXT TO RESIDENCE BUILDING 1686 ANDREWS AFB MD	
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier  JOYCE A. LAPA				29c. License number D39738	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) JULY 18, 1996				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARMED FORCES INSTITUTE OF PATHOLOGY				31. Data filed (Month, Day, Year) JUL 23 1996	
	32. Registrar's Signature 				33. Registrar's Name DAVIDSON-RANDALL				34. Registrar's Title REGISTRAR	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHHM 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23246

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sheryl Lucreita Allen				2. Date of Death Month Day Year June 30 1996		3. Time of Death 7:00 AM	
	4a. Facility Name (If not institution, give street and number) Memorial Hospital at Easton				4b. City, Town, or Location of Death Easton		4c. County of Death Talbot	
Funeral Director	5. Social Security Number 216 80 5620		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 33 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 14, 1962 MD.	
	9. Birthplace (State or Foreign Country)							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State MD.		10b. County Talbot		10c. City, Town or Location Easton			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 803 Arcaia Street				10f. Zip Code 21601		10g. Citizen of What Country? USA	
	11. Marital Status <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic		16b. Kind of Business/Industry Domestic-House			
	17. Father's Name (First, Middle, Last) Russell Simms				18. Mother's Name (First, Middle, Maiden Surname) Onetta Allen			
	19a. Informant's Name/Relationship (Type, Print) Onetta Allen - Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 803 Arcaia St. Easton, MD. 21601			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Richardson Cemet. 7-6-96		Date Easton, MD.		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility Williamson-Fluharty Funeral Services, P.A. Easton, Maryland 21601			
	Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
Immediate Cause (Final disease or condition resulting in death) e. Cardiac Arrest Due to (or as a consequence of):							< 1 HR.	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Aspiration Due to (or as a consequence of):							2 HRS.	
c. Due to (or as a consequence of):								
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Seizure Disorder, History of Brain Tumor Gastric Reflux							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Charles E. DiNapoli MD				29c. License number D 38990		29d. Date signed (Month, Day, Year) July 1, 1996	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles E. DiNapoli MD 404 Marvel Ct. Easton, MD 21601							
	31. Date filed (Month, Day, Year) JUL 26 1996		32. Registrar's Signature Julia Davidson-Randall					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23247
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY JANE BOSWELL				2. Date of Death Month Day Year JULY 27, 1996		3. Time of Death 8:15 PM		
	4a. Facility Name (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL				4b. City, Town, or Location of Death OLNEY		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 579-20-4882		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 73	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAY 2, 1923	9. Birthplace (State or Foreign Country) WASHINGTON, D.C.	
	Usual Residence of Decedent								
10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location LAYTONSVILLE			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 5 GRIFFITH COURT				10f. Zip Code 20882		10g. Citizen of What Country? UNITED STATES			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry OWN HOME		
17. Father's Name (First, Middle, Last) TOBY HAMMETT				18. Mother's Name (First, Middle, Maiden Surname) MARGARET COGAN					
19a. Informant's Name/Relationship (Type, Print) JAMES E. BOSWELL, SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 812 QUINCE ORCHARD BLVD. GAITHERSBURG, MD. 20878					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY		Date 7/29/96		20c. Location - City or Town, State ALEXANDRIA, VIRGINIA		
21. Signature of Funeral Service Licensee Muriel H. Barber				22. Name and Address of Facility MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. RESPIRATORY FAILURE Due to (or as a consequence of): C.O.P.D. b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death DAYS years	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. atrial fibrillation, acute renal failure						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier N. Coyle MD							
29c. License number D50457		29d. Date signed (Month, Day, Year) JULY 28, 1996							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Coyle MD, 1811 Prince Philip Dr, Olney MD 20832									
31. Date filed (Month, Day, Year) AUG 06 1996		32. Registrar's Signature John Shuler-Randall							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 23248

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Raymond Woodrow Brubacher				2. DATE OF DEATH MONTH DAY YEAR July 26, 1996		3. TIME OF DEATH 12:30 P M	
4. SOCIAL SECURITY NUMBER 213-38-3802		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct 12, 1912	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. CITY, TOWN OR LOCATION OF DEATH Leonardtwn		9b. COUNTY OF DEATH St. Mary's			
9c. FACILITY NAME (If not institution, give street and number) Rt. 1 Box 73							
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY St. Mary's		10c. CITY, TOWN OR LOCATION Leonardtwn		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER Rt. 1 Box 73				10f. ZIP CODE 20650		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Farmer		16b. KIND OF BUSINESS/INDUSTRY Farm			
17. FATHER'S NAME (First, Middle, Last) Robert Henry Brubacher				18. MOTHER'S NAME (First, Middle, Maiden Surname) Johanna Hubin			
19a. INFORMANT'S NAME (Type/Print) Mary Alice Brubacher				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 1 Box 73, Leonardtown, Maryland 20650			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Trinity Memorial Gardens 7/29/96		20c. LOCATION — City or Town, State Waldorf, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael L. Gardiner</i>				22. NAME AND ADDRESS OF FACILITY Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <i>Carcinomatosis</i> b. DUE TO (OR AS A CONSEQUENCE OF): <i>Carcinoma of Colon</i> c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <i>48 hrs</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO <i>N.A.</i>
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Patrick Jarboe, M.D.</i>				29c. LICENSE NUMBER D 06419		29d. DATE SIGNED (Month, Day, Year) 7/26/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Patrick Jarboe, M.D. Leonardtown, Maryland 20650							
31. DATE FILED (Month, Day, Year) JUL 30 1996				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23249

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ARTHUR L. BESSETTE

2. Date of Death

JULY 19, 1996 9:20 AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

3330 North Leisure World Blvd.

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

040-14-1377

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 7, 1919

9. Birthplace (State or Foreign Country)

Connecticut

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3330 N. Leisure World Blvd., #314

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II 1943-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dentist

16b. Kind of Business/Industry

Dental Care

17. Father's Name (First, Middle, Last)

Arthur Xavier Bessette

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Laberge

19a. Informant's Name/Relationship (Type, Print)

Grace Ferrara Bessette (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3330 N. Leisure World Blvd. #314, Silver Spring, MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery 07-22-96

Date

20c. Location - City or Town, State

Silver Spring, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines/Rinaldi Funeral Home

11800 New Hampshire Ave., Silver Spring, MD.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pancreatic Cancer

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

11 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

DIRECTOR, MEDICAL ONCOLOGY

29c. License number

D23675

29d. Date signed (Month, Day, Year)

July 19, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROSS DONCHOWER, M.D. Johns Hopkins Oncology Ctr.; Baltimore, MD 21207

31. Date filed (Month, Day, Year)

JUL 24 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23250

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Patsy L. Buchanan				2. Date of Death Month Day Year July 21 1996		3. Time of Death 6:51 p.m.																										
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery																										
Funeral Director	5. Social Security Number 578-22-7376		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 23, 1924																										
	9. Birthplace (State or Foreign Country) Minnesota		10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location Bowie																										
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 11907 Galaxy Lane		10f. Zip Code 20715		10g. Citizen of What Country? USA																										
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White																										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Flight Data Specialist		16b. Kind of Business/Industry Federal Aviation Admin.																												
	17. Father's Name (First, Middle, Last) Harry Limparis				18. Mother's Name (First, Middle, Maiden Surname) Sophia Wojciak																												
	19a. Informant's Name/Relationship (Type, Print) Eugenia D. Curtin / Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15109 Middlegate Road, Silver Spring, Maryland 20905																												
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		Date 7/25/96		20c. Location - City or Town, State Silver Spring, Maryland																										
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904																												
	23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Left Massive Hemothorax</td> <td>Approximate Interval Between Onset and Death Minutes</td> </tr> <tr> <td>b.</td> <td>Hypoxic Encephalopathy</td> <td>4 Months</td> </tr> <tr> <td>c.</td> <td>Acute Tubular Necrosis</td> <td>Several Months</td> </tr> <tr> <td>d.</td> <td>Coronary Artery Disease (Left Main)</td> <td>Several Years</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a.	Left Massive Hemothorax	Approximate Interval Between Onset and Death Minutes	b.	Hypoxic Encephalopathy	4 Months	c.	Acute Tubular Necrosis	Several Months	d.	Coronary Artery Disease (Left Main)	Several Years												
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<table border="1"> <tr> <td colspan="2">25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="6">26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="2">27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined</td> <td colspan="2">28a. Date of injury (Month, Day, Year)</td> <td colspan="2">28b. Time of injury M</td> <td colspan="2">28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> <td colspan="2">28d. Describe how injury occurred</td> </tr> <tr> <td colspan="4">28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="4">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table>								25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
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<table border="1"> <tr> <td colspan="8">29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</td> </tr> <tr> <td colspan="4">29b. Signature and title of certifier </td> <td colspan="2">29c. License number D42082</td> <td colspan="2">29d. Date signed (Month, Day, Year) July 22, 1996</td> </tr> </table>								29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier 				29c. License number D42082		29d. Date signed (Month, Day, Year) July 22, 1996											
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29b. Signature and title of certifier 				29c. License number D42082		29d. Date signed (Month, Day, Year) July 22, 1996																											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Tzeng, M.D. 7501 Surratts Rd., #303, Clinton, MD 20735																																	
<table border="1"> <tr> <td colspan="2">31. Date filed (Month, Day, Year) JUL 25 1996</td> <td colspan="6">32. Registrar's Signature </td> </tr> </table>								31. Date filed (Month, Day, Year) JUL 25 1996		32. Registrar's Signature 																							
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Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23251

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bertha F. Barnes				2. Date of Death Month Day Year July 17, 1996				3. Time of Death 6:37 A.M.			
	4a. Facility Name (If not institution, give street and number) 1506 Bishop Road				4b. City, Town, or Location of Death Edgewater				4c. County of Death Anne Arundel			
Funeral Director	5. Social Security Number 579-22-4370		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 7, 1916		9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Edgewater				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 1506 Bishop Road				10f. Zip Code 21037				10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Ralph Clayton				18. Mother's Name (First, Middle, Maiden Surname) Bertha May Dean							
	19a. Informant's Name/Relationship (Type, Print) Bernard F. Barnes, Jr./son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1726 Ridgely Road, Edgewater, Maryland 21037							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park				20c. Location - City or Town, State Rockville, Maryland			
	21. Signature of Funeral Service Licensee Ray Faulk M00198				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. CARDIAC ARREST (SUDDEN DEATH) Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d.											
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No												
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES											
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
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To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred			
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	29b. Signature and title of certifier S. — m				29c. License number P4169B				29d. Date signed (Month, Day, Year) 7-19-96			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPHEN C. HAMILTON, MD 205 RIDGELY AVE, ANNAPOLIS, MD 21401											
	31. Date filed (Month, Day, Year) JUL 23 1996				32. Registrar's Signature Julia Davidson-Randall							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

96 23252

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Helen Martha Hoen Brown				2. DATE OF DEATH MONTH DAY YEAR July 27, 1996		3. TIME OF DEATH 12:09 PM	
4. SOCIAL SECURITY NUMBER 223-09-1263		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 80 YRS.	7. DATE OF BIRTH (Month, Day, Year) April 11 1916		8. BIRTHPLACE (State or Foreign Country) Virginia	
9a. FACILITY NAME (If not institution, give street and number) Westminster Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Westminster		9c. COUNTY OF DEATH Carroll	
10a. STATE Maryland		10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Mt. Airy		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 17500 Frederick Rd.				10f. ZIP CODE 21771		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Stanley Hoen				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sadie Kern			
19a. INFORMANT'S NAME (Type/Print) George Brown, husband				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17500 Frederick Rd., Mt. Airy, Maryland 21771			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremations		20c. LOCATION — City or Town, State Hampstead, MD		20d. DATE OF DISPOSITION 07/28/96	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Katherine Potts - Switzer				22. NAME AND ADDRESS OF FACILITY Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD 21157			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Myocardial Infarction Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Coronary Artery Disease						Approximate Interval Between Onset and Death Ten Minutes Ten Years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Seizure Disorder, Hypertension, Hypothyroidism						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D33184		29d. DATE SIGNED (Month, Day, Year) July 28, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jonathan D. Kushner 114 Business Center Drive Reisterstown, MD							
31. DATE FILED (Month, Day, Year) JUL 29 1996		32. REGISTRAR'S SIGNATURE John Andrew Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23253

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William JAMES Butler				2. Date of Death Month Day Year 07 - 18 - 96				3. Time of Death 9:35 p.m.		
	4a. Facility Name (If not institution, give street and number) Caroline Nursing Home				4b. City, Town, or Location of Death Denton, MD				4c. County of Death Caroline		
Funeral Director	5. Social Security Number 218-07-3606		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 11, 1911		9. Birthplace (State or Foreign Country) MARYLAND		
	Usual Residence of Decedent										
10a. State MD		10b. County CAROLINE		10c. City, Town or Location RIDGELY				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 407 STRAWBERRY COURT				10f. Zip Code 21660				10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 Collega (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER				16b. Kind of Business/Industry PROPANE GAS CO.			
17. Father's Name (First, Middle, Last) WILLIAM JAMES BUTLER				18. Mother's Name (First, Middle, Maiden Summa) VERN VIRGINIA ANTHONY							
19a. Informant's Name/Relationship (Type, Print) LISA MARIE WALTERS				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24160 SPARKS RD., RIDGELY, MD 21660							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SPRING HILL CEMETERY		Data 7-22		20c. Location - City or Town, State EASTON, MD					
21. Signature of Funeral Service Licensee John R. Merle				22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 200 S. HARRISON ST., EASTON, MD							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Bile duct obstruction Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death 1 month	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and Title of certifier James Sides				29c. License number D31376		29d. Date signed (Month, Day, Year) 9-19-96	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Sides 920 Market St Denton											
31. Date filed (Month, Day, Year) JUL 23 1996				32. Registrar's Signature Lisa Davidson-Randall							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at 202-696-2000.

Division of Vital Records, P.O. Box 68760,

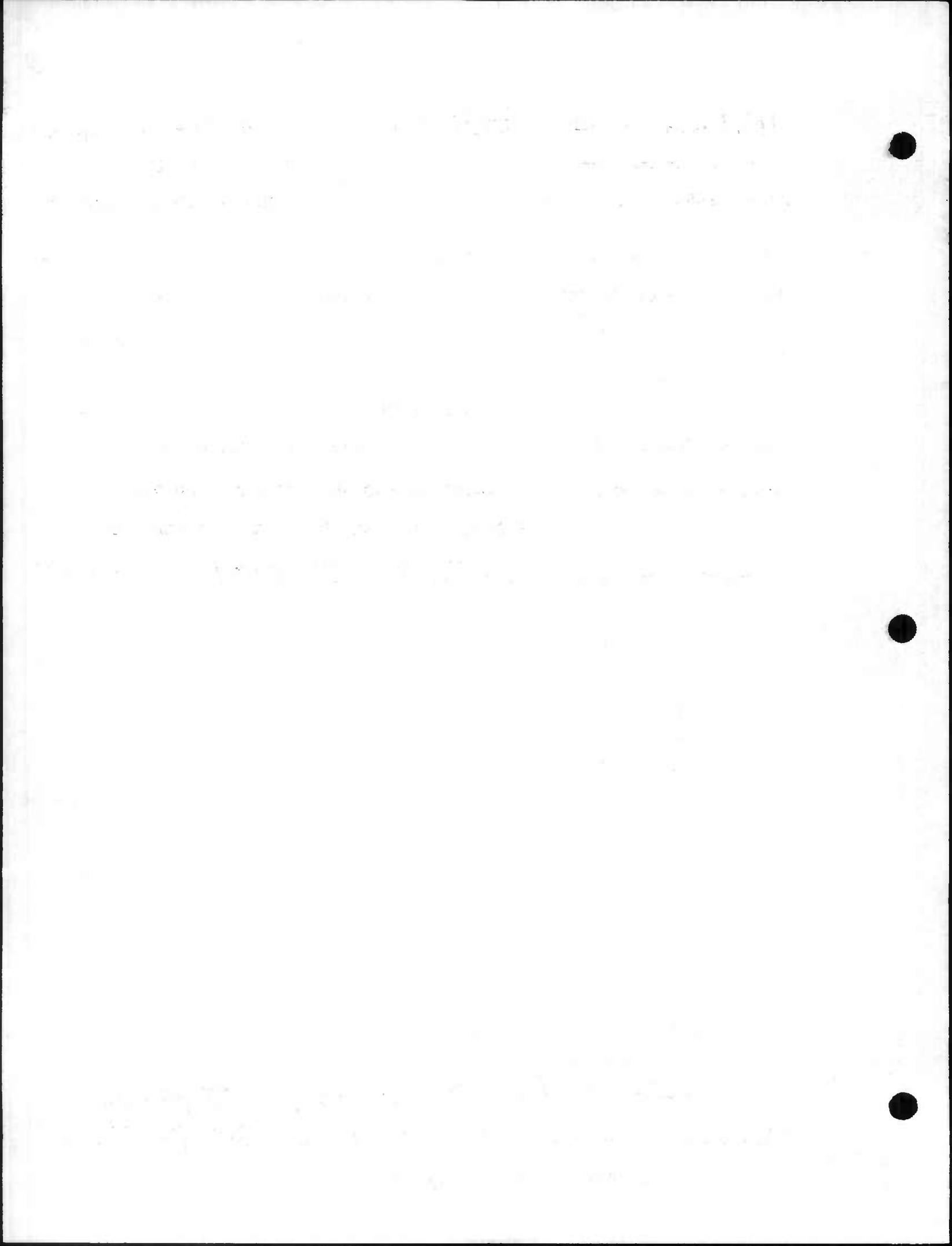
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23254

Amended #6,7/24/96, D1B, St. Mary's

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDMOND LEROY COOK				2. Date of Death Month: July Day: 19 Year: 1996		3. Time of Death 5:41 A.M.	
	4a. Facility Name (If not institution, give street and number) St. Mary's Hospital				4b. City, Town, or Location of Death Leonardtwn		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 050-18-8597		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) February 5, 1922	
	9. Birthplace (State or Foreign Country) Washington, D.C.							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Lexington Park			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 45496 Holly Road				10f. Zip Code 20653		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW2		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Rigger		16b. Kind of Business/Industry Defense	
	17. Father's Name (First, Middle, Last) Charles F. Cook				18. Mother's Name (First, Middle, Maiden Summa) Rose L. Boarman			
	19a. Informant's Name/Relationship (Type, Print) Virginia Ann Brown				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) General Delivery, Compton, Maryland 20627			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Immaculate Heart of Mary Cemetery		Data July 23, 1996		20c. Location - City or Town, State Lexington Park, MD	
	21. Signature of Funeral Home Director Edward N. Brinsfield, Jr., M00052				22. Name and Address of Facility Brinsfield Funeral Home, P.A. 59 N. Washington St., Leonardtown, MD 20650-0279			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic ca to Central Nervous Systems, Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Coronary heart disease s/p. Ca of Esophagus								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pandemic investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Yongsik Moon M.D.				29c. License number D09178		29d. Date signed (Month, Day, Year) July 19, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YOUNGSIK MOON M.D. HOLLYWOOD, MD 20636								
31. Date filed (Month, Day, Year) JUL 23 1996		32. Registrar's Signature John Davidson-Randall						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23255

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GLADYS WHITE CLAMPITT

2. Date of Death

Month Day Year
JULY 19, 1996

3. Time of Death

7:20 P:M

4a. Facility Name (If not institution, give street and number)

CARRIAGE HILL NURSING HOME

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

576-60-7744

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
OCT. 28, 1903

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

WASHINGTON, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3901 CONNECTICUT AVE., N.W. # 401

10f. Zip Code

20008

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JOSEPH BAKER WHITE

18. Mother's Name (First, Middle, Maiden Surname)

CAROLINE CARROLL

19a. Informant's Name/Relationship (Type, Print)

CAROLYN A. CLAMPITT, DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3901 CONNECTICUT AVE., N.W. WASHINGTON, DC. 20008

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ROCK CREEK CEMETERY

Date

7/24

20c. Location - City or Town, State

WASHINGTON, D.C.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOSEPH GAWLER'S SONS, INC. 5130 WISCONSIN AVE.
N.W., WASHINGTON, D.C. 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

RESPIRATORY FAILURE

Due to (or as a consequence of):

CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

MINS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. GEORGE GRAVES 5530 WISCONSIN AVE. CHEVY CHASE, MD. 20815

31. Date filed (Month, Day, Year)

JUL 25 1996

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

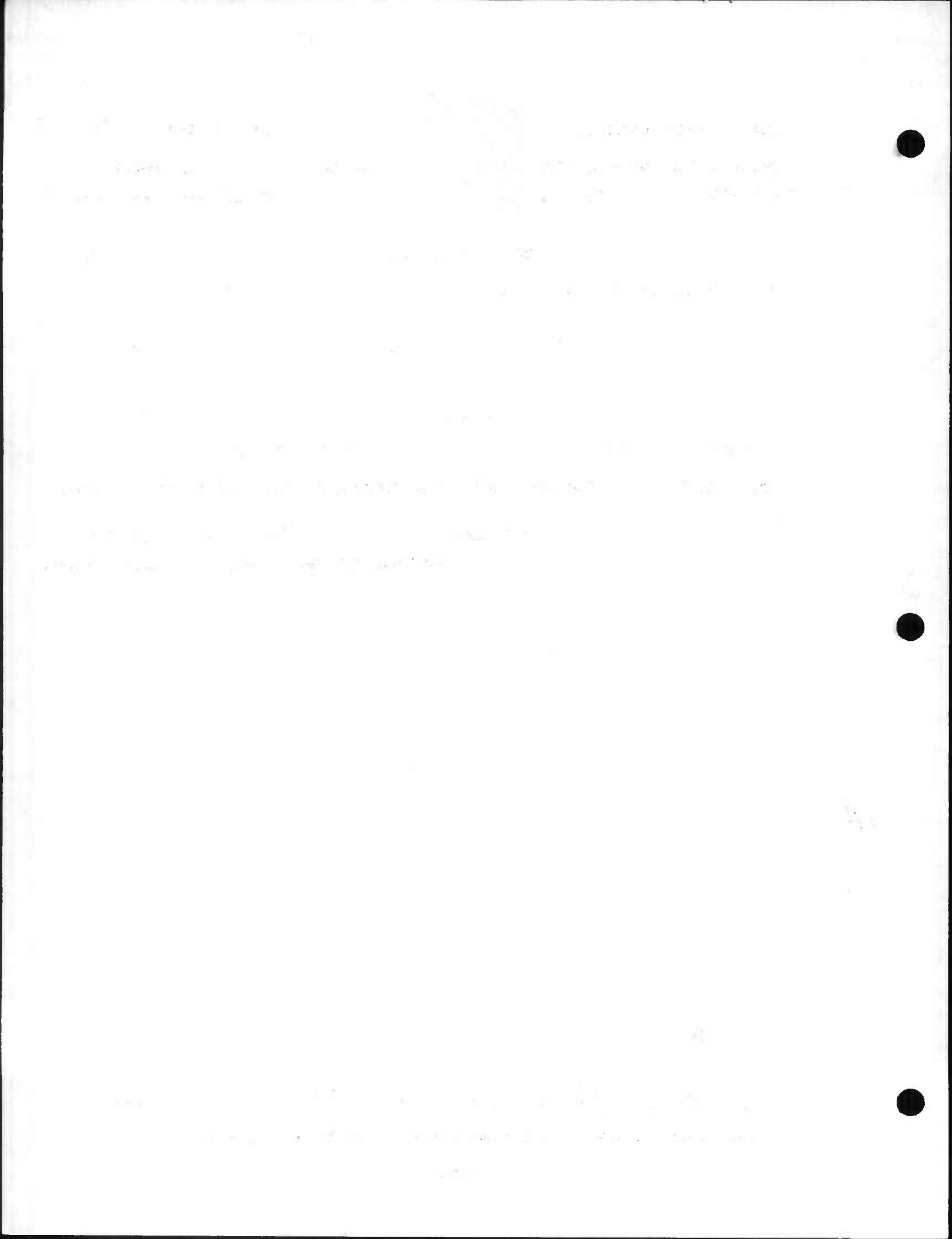
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23256

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHRISTOPHER D. CHUNG		2. Date of Death Month JULY Day 18 , Year 1996		3. Time of Death 1324 PM
	4a. Facility Name (If not institution, give street and number) LAUREL REGIONAL HOSPITAL		4b. City, Town, or Location of Death LAUREL		4c. County of Death PRINCE GEORGES
Funeral Director	5. Social Security Number 216-21-6947	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 8 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) July 9, 1988		9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10e. State Maryland	10b. County Montgomery	10c. City, Town or Location Silver Spring		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 12308 Palermo Drive		10f. Zip Code 20904		10g. Citizen of What Country? United States
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Asian		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) Student		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student		16b. Kind of Business/Industry		
	17. Father's Name (First, Middle, Last) Young Sik Chung		18. Mother's Name (First, Middle, Maiden Surname) Dong Hwa Kim		
	19a. Informant's Name/Relationship (Type, Print) Young Sik Chung (Father)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) George Washington Cemetery		20c. Location - City or Town, State Adelphi, Maryland
	21. Signature of Funeral Service Licensee <i>Donald V. Borgwardt</i>		22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705		
23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Drowning Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 7-18-96		28b. Time of Injury 1215P. M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject drowned in pool			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Public Pool		28f. Location (Street and Number or Rural Route Number, City or Town, State) 13820 Oldbury Road			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>John Locke MD</i>		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) JULY 19, 1996	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Locke, MD 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) JUL 25 1996		32. Registrar's Signature <i>Davidson-Randall</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23257

Amended #1, 17, 19a, 7/25/96, MRT, M6 Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert J. Curtin, Jr.				2. Date of Death Month July Day 23 Year 1996				3. Time of Death 2:10PM	
	4a. Facility Name (If not institution, give street and number) 18418 Point Seneca Place				4b. City, Town, or Location of Death Germantown				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 214-48-5489		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) 50 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 16, 1945		9. Birthplace (State or Foreign Country) Washington, DC	
	Usual Residence of Decedent				10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Germantown	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 18418 Point Seneca Place		10f. Zip Code 20874		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Vietnam		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Intelligence Officer				16b. Kind of Business/Industry Federal Government	
	17. Father's Name (First, Middle, Last) Robert James Curtin				18. Mother's Name (First, Middle, Maiden Surname) Victoria Bottash					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mary E. Curtin Mary Curtin/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18418 Point Seneca Place, Germantown, Maryland 20874					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.		20c. Location - City or Town, State Bethesda, Maryland		20d. Date July 26, 1996			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee  M00198				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 W. Montgomery Avenue, Rockville, Maryland 20850-2805					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lung Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 9 months					
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number ID 314053	
	29d. Date signed (Month, Day, Year) July 24, 1996				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nelson G.N. Kahl, M.D. National Naval Medical Center, Bethesda, Maryland 20889					
State Registrar	31. Date filed (Month, Day, Year) JUL 25 1996				32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23258

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DONALD ROY CLARK				2. Date of Death Month 7 Day 19 Year 96		3. Time of Death 6:13 AM		
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 508-10-9396		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 12, 1920	9. Birthplace (State or Foreign Country) Nebraska	
	Usual Residence of Decedent								
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Kensington			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 4202 Brookfield Drive				10f. Zip Code 20895		10g. Citizen of What Country? United States			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1944-1947		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanical Engineer		16b. Kind of Business/Industry Naval Ordnance Laboratory			
17. Father's Name (First, Middle, Last) David Roy Clark				18. Mother's Name (First, Middle, Maiden Surname) Mattie Critchfield					
19a. Informant's Name/Relationship (Type, Print) Lily A. Clark / wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4202 Brookfield Drive, Kensington, Maryland 20895					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.		Date July 21, 1996		20c. Location - City or Town, State Bethesda, Maryland			
21. Signature of Funeral Service Licensee <i>Karina G. McMullen Lawrence</i>		M00831		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PANCREATIC CARCINOMA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death WKS.									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. INTESTINAL OBSTRUCTION-SECONDARY TO PANCREATIC CARCINOMA									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Albert H. Grollman MD							
29c. License number DO2404		29d. Date signed (Month, Day, Year) JULY 19, 1996							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALBERT H. GROLLMAN MD. 1106 SPANGLER STREET SILVER SPRING, MD 20910									
31. Date filed (Month, Day, Year) JUL 23 1996		32. Registrar's Signature <i>John Davidson Randall</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23259

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MELVETTA A. CUMMINGS				2. Date of Death Month JULY Day 23 Year 1996		3. Time of Death 4:22 AM		
	4a. Facility Name (If not Institution, give street and number) CORSICA HILL NURSING HOME				4b. City, Town, or Location of Death CENTREVILLE		4c. County of Death QUEEN ANNE		
Funeral Director	5. Social Security Number 213-92-5486		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) APR. 15, 1916	9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD	10b. County TALBOT	10c. City, Town or Location EASTON			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 25 CRABAPPLE COURT				10f. Zip Code 21601		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE			16b. Kind of Business/Industry OWN HOME			
	17. Father's Name (First, Middle, Last) EDWARD ALBERT HADDAWAY				18. Mother's Name (First, Middle, Maiden Surname) IDA VIRGINIA LEDNUM				
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) CHARLES L. CUMMINGS, JR.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30858 RABBITT HILL RD., CORDOVA, MD 21625				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) TILGHMAN CEMETERY		Date 7-25		20c. Location - City or Town, State TILGHMAN, MD		
	21. Signature of Funeral Service Licensee JOHN R. MERCERON CFS				22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 200 S. HARRISON ST., EASTON, MD				
	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <u>renal failure</u></p> <p>Due to (or as a consequence of):</p> <p>b. <u>hypertension</u></p> <p>Due to (or as a consequence of):</p> <p>c. <u>cerebrovascular accident</u></p> <p>Due to (or as a consequence of):</p> <p>d. <u>diabetes mellitus</u></p> </div> <div> <p>Approximate Interval Between Onset and Death</p> <p><u>days</u></p> <p><u>years</u></p> <p><u>year</u></p> <p><u>years</u></p> </div> </div>								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>dementia</u>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Kathleen Hoey		29c. License number D47627		29d. Date signed (Month, Day, Year) 07-23-96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KATHLEEN HOEY, M.D., 207 N. LIBERTY ST B, CENTREVILLE, MD 21617									
31. Date filed (Month, Day, Year) JUL 26 1996		32. Registrar's Signature Gisha Davidson-Randall							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

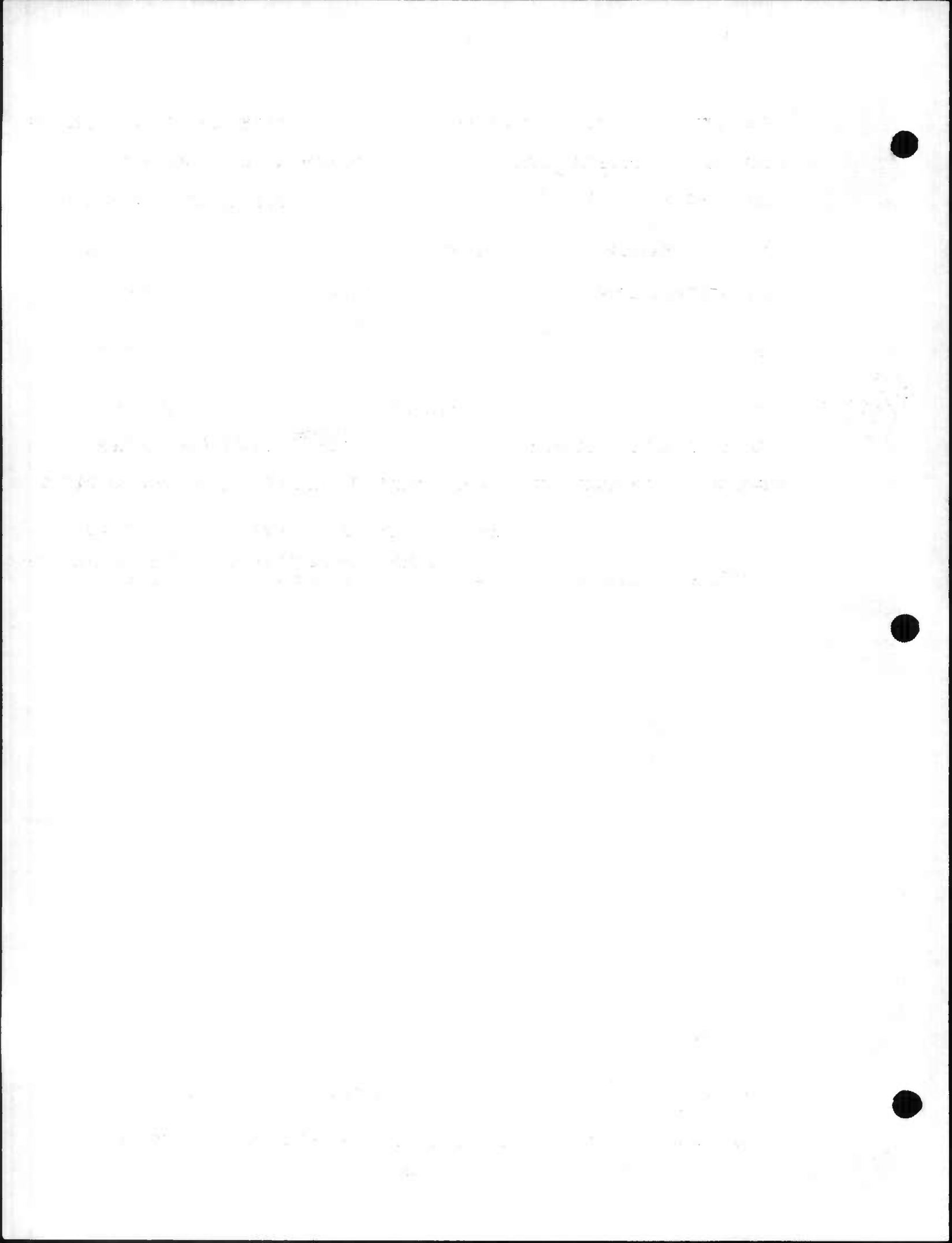
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23260

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bella W. Crowder				2. Date of Death Month July Day 24 Year 1996				3. Time of Death 11:35 PM	
	4a. Facility Name (If not institution, give street and number) The Pines				4b. City, Town, or Location of Death Easton				4c. County of Death Talbot	
Funeral Director	5. Social Security Number 177-10-5368D		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 101 Yrs.		8. Date of Birth (Month, Day, Year) JULY 30, 1894		9. Birthplace (State or Foreign Country) PENNSYLVANIA	
	Usual Residence of Decedent				10a. State MD		10b. County TALBOT		10c. City, Town or Location EASTON	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 6685 MANADIER ROAD				10f. Zip Code 21601	
	10g. Citizen of What Country? USA				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER				16b. Kind of Business/Industry OWN HOME				17. Father's Name (First, Middle, Last) JOHN THOMAS WEEKS	
	18. Mother's Name (First, Middle, Maiden Surname) MARGARET AGNES PARKER				19a. Informant's Name/Relationship (Type, Print) LEE CROWDER/ SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6685 MANADIER ROAD, EASTON, MD 21601	
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATORY				20c. Location - City or Town, State 7-25 CHESTER, MD	
	21. Signature of Funeral Service Licensee <i>B. Keith Phipps, CFS</i>				22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 200 S. HARRISON ST., EASTON, MD				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory insufficiency Due to (or as a consequence of): b. Chronic obstructive pulmonary disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how Injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier <i>B. Keith Phipps, MD</i>				29c. License number D25933				29d. Date signed (Month, Day, Year) 7.25.96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Crowder MD 508 Edgewood Avenue, Easton, MD 21601				31. Date filed (Month, Day, Year) JUL 26 1996				32. Registrar's Signature <i>L. Davidson-Randall</i>		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

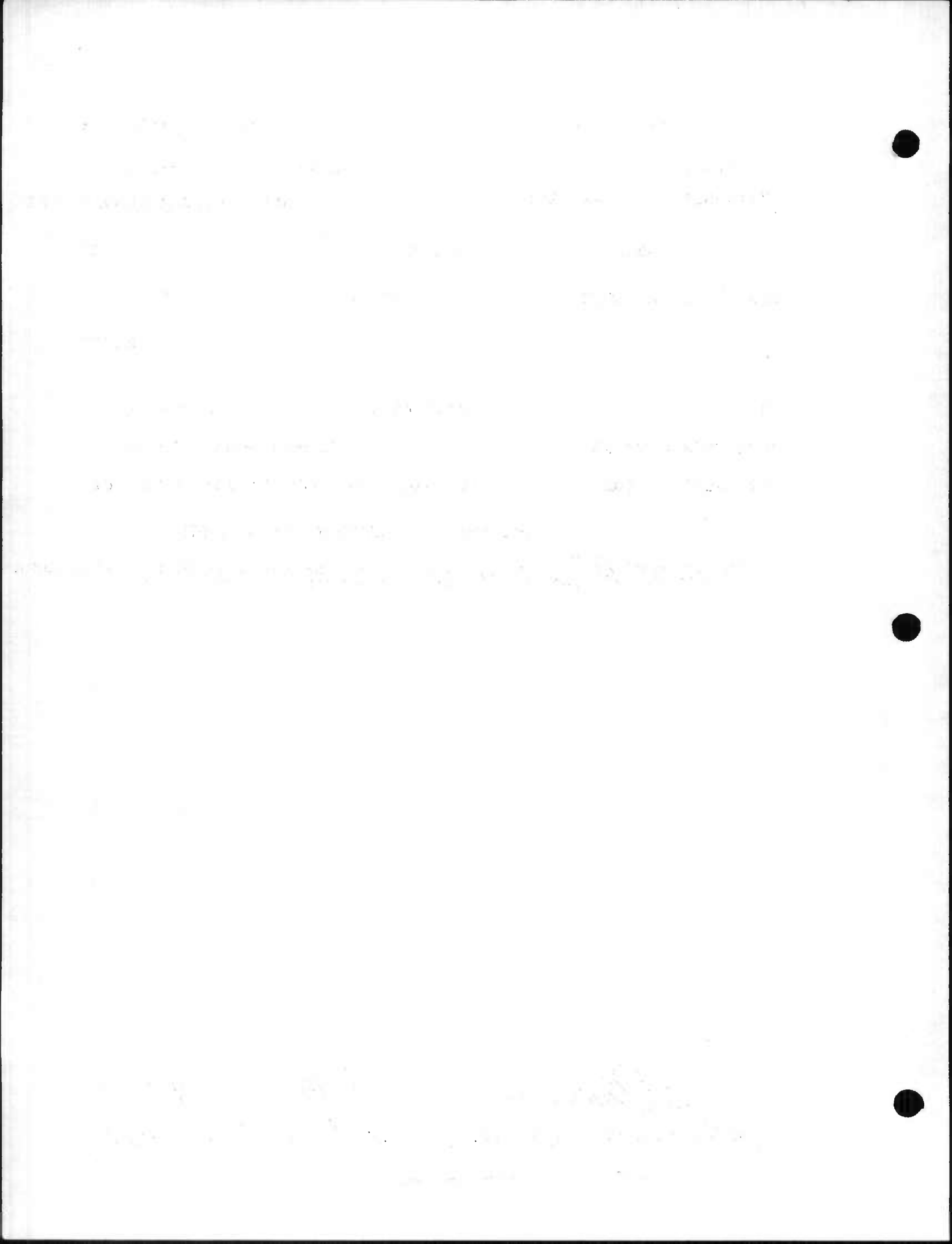
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23261

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLOTTE MAY CHRISTIE				2. Date of Death Month Day Year July 21 1996		3. Time of Death 10:27p	
	4a. Facility Name (If not institution, give street and number) Memorial Hospital at Easton				4b. City, Town, or Location of Death Easton		4c. County of Death Talbot	
Funeral Director	5. Social Security Number 220-38-5420	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 54 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) SEPT. 29, 1941		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County QUEEN ANNE	10c. City, Town or Location CENTREVILLE			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 1617 HOPE ROAD			10f. Zip Code 21617		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE			16b. Kind of Business/Industry OWN HOME		
	17. Father's Name (First, Middle, Last) LOUIS E. McDERMOTT				18. Mother's Name (First, Middle, Maiden Surname) ELEANOR SNYDER			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) CHARLES P. CHRISTIE, JR.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1617 HOPE ROAD, CENTREVILLE, MD 21617			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) WOODLAWN MEMORIAL PARK 7-24		20c. Location - City or Town, State EASTON, MD			
	21. Signature of Funeral Service Licensee JOHN R. MERCER				22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 200 S. HARRISON ST., EASTON, MD 21601			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. metastatic renal cell cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 1yr
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and Title of Certifier Peter Whitesell MD		29c. License number D44749	29d. Date signed (Month, Day, Year) 7/22/96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PETER WHITESELL, M.D., 508 IDLEWILD AVE., EASTON, MD 21601								
State Registrar	31. Date filed (Month, Day, Year) JUL 23 1996		32. Registrar's Signature Lelia Davidson-Randall					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1. The first part of the report is devoted to a general survey of the situation in the country.

2. The second part of the report is devoted to a detailed analysis of the economic situation in the country.

3. The third part of the report is devoted to a detailed analysis of the social situation in the country.

4. The fourth part of the report is devoted to a detailed analysis of the political situation in the country.

5. The fifth part of the report is devoted to a detailed analysis of the cultural situation in the country.

6. The sixth part of the report is devoted to a detailed analysis of the international situation in the country.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23262

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rochael MAEBELLE Davis			2. Date of Death Month July Day 17 Year 1996		3. Time of Death 8:30 A	
	4a. Facility Name (If not institution, give street and number) Suburban Hospital			4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 220-16-0575		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 11, 1923
	9. Birthplace (State or Foreign Country) Maryland						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Rockville			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 607 Rollins Avenue			10f. Zip Code 20852		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) James Ord Stroup			18. Mother's Name (First, Middle, Maiden Surname) Annie B. Routzahn			
	19a. Informant's Name/Relationship (Type, Print) Robert C. Davis			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 607 Rollins Avenue, Rockville, MD 20852			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 7/17/96	20c. Location - City or Town, State alexandria, Virginia	
	21. Signature of Funeral Service Licensee Michael D. Gibbons			22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC COLON CARCINOMA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Severe MALNUTRITION Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			Approximate Interval Between Onset and Death years			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe MALNUTRITION			23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier John Gloger MD		29c. License number 0 44580		29d. Date signed (Month, Day, Year) JULY 17, 1996
30. Name and address of person who completed cause of death (item 23e) (Type, Print) Mark Gloger, 9711 medical center Drive, Rockville, MD 20850							
31. Date filed (Month, Day, Year) JUL 24 1996			32. Registrar's Signature John Davidson-Randall				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12

State
Registrar

2nd 1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th

1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th
1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th
1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th

96 23263

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ernest W. Edens, Sr.				2. DATE OF DEATH MONTH July DAY 22 YEAR 1996		3. TIME OF DEATH 0204 M	
4. SOCIAL SECURITY NUMBER 214-30-0335		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH MONTH April DAY 3 YEAR 1932	
9a. FACILITY NAME (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH ROCKVILLE		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE MARYLAND				10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION GAITHERSBURG	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 7501 LAYTONIA DRIVE			
10f. ZIP CODE 20877				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HEAVY EQUIPMENT OPERATOR		16b. KIND OF BUSINESS/INDUSTRY STATE ROAD DEPARTMENT			
17. FATHER'S NAME (First, Middle, Last) WILLIAM EDENS				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARTHA (UNKNOWN)			
19a. INFORMANT'S NAME (Type/Print) DIANA M. EDENS, DAUGHTER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7501 LAYTONIA DRIVE, GAITHERSBURG, MD. 20877			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) TRUE GOSPEL CEMETERY		DATE 7/26/96		20c. LOCATION — City or Town, State LISBON, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Muriel H. Barber				22. NAME AND ADDRESS OF FACILITY MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ASYSTOLE Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST MYOCARDIAL INFARCTION PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PNEUMONIA DIABETES MELLITUS, PULMONARY EDEMA DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							Approximate interval Between Onset and Death MINUTE 10 days
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D 28656		29d. DATE SIGNED (Month, Day, Year) July 22, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAMI PASSI MD. 8609 SECOND AVENUE, 404B. SILVER SPRING, MD. 20910							
31. DATE FILED (Month, Day, Year) JUL 25 1996		32. REGISTRAR'S SIGNATURE [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended #1, 7/24/96, MRT, Montg. Cty. **Certificate of Death**

96 23264

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Francis G. Fabrizio

2. Date of Death

July 16, 1996

3. Time of Death

3:45 pm

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

577-12-3446

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 28, 1913

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

New Carrollton

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

8315 Longfellow Street

10f. Zip Code

20784

10g. Citizen of What Country?

United States

11. Marital Status

☒ Never Married ☐ Married

☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

12 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Peter A. Fabrizio

18. Mother's Name (First, Middle, Maiden Surname)

Katherine R. Gerardi

19a. Informant's Name/Relationship (Type, Print)

Donald V. Fabrizio - Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8315 Longfellow Street, New Carrollton, MD 20784

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State

☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mary's Cemetery

Date

7-19-96

20c. Location - City or Town, State

Washington, D.C.

21. Signature of Funeral Service licensee

[Signature]

22. Name and Address of Facility

Hines-Rinaldi Funeral Home, Inc.

11800 New Hampshire Avenue, Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ASCVD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

60 min.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☒ ER/Outpatient ☐ DOA

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation

☐ Accident ☐ Could not be determined

☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician

☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

D28640

29d. Date signed (Month, Day, Year)

July 17, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011 Sentry Circle Apt 102 Odenton MD 21113

31. Date filed (Month, Day, Year)

JUL 24 1996

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended #20b, 20c, 7/22/96, MRT, Montg, City

State of Maryland / Department of Health and Mental Hygiene

96 23265

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruby Mabel Farquhar			2. Date of Death Month Day Year July 4, 1996		3. Time of Death 7:45 AM	
	4a. Facility Name (If not Institution, give street and number) 6116 Western Avenue			4b. City, Town, or Location of Death Chevy Chase		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 577-22-9773		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 5, 1902
	9. Birthplace (State or Foreign Country) England						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Chevy Chase			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 6116 Western Ave.,		10f. Zip Code 20815		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Gary Leahy			18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth Wildman			
	19a. Informant's Name/Relationship (Type, Print) Gerald W. Farquhar			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4407 Hadfield Lane, N.W., Wash. D.C. 20007			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington Nat'l Cem. Gate of Heaven Cem.		20c. Location - City or Town, State Arlington, VA Silver Spring, Md.		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility DeVol Funeral Home 2222 Wisc. AVE, N.W., Washington, D.C. 20007			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Bronchiectasis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)
29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 			29c. License number D27465		29d. Date signed (Month, Day, Year) JULY 5, 1996		
30. Name and address of person who completed cause of death (Item 28a) (Type, Print) Robert W. Langevin, M.D. 5454 Wisconsin Ave., #1125 Chevy Chase, Maryland 20815							
31. Date filed (Month, Day, Year) JUL 11 1996		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23266

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Ann Freudenthal				2. Date of Death Month Day Year July 19, 1996				3. Time of Death 1:40PM		
	4a. Facility Name (If not Institution, give street and number) Manor Care-Potomac				4b. City, Town, or Location of Death Potomac				4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 129-24-3767		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) June 4, 1912		9. Birthplace (State or Foreign Country) Poland		
	Usual Residence of Decedent				10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Chevy Chase		
To Be Completed by Funeral Director	10e. Street and Number 4620 North Park Avenue, #1008W				10f. Zip Code 20815		10g. Citizen of What Country? United States				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Librarian		16b. Kind of Business/Industry United States Government				
	17. Father's Name (First, Middle, Last) Jacob Silberstein				18. Mother's Name (First, Middle, Maiden Surname) Gazella not available						
	19a. Informant's Name/Relationship (Type, Print) Yaron M. Sternberg / cousin				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11905 Viewcrest Terrace, Silver Spring, MD 20902						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.		20c. Date July 20, 1996		20d. Location - City or Town, State Bethesda, Maryland				
	21. Signature of Funeral Service Licensee <i>Barbara J. McMullen-Laurence</i> M00831				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Stroke Due to (or as a consequence of): Peripheral Vascular Disease Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chronic Obstructive Pulmonary Disease				Approximate Interval Between Onset and Death Week Years						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulmonary Disease				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>John Davidson-Randall</i>		29c. License number 039456		29d. Date signed (Month, Day, Year) July 19, 1996					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lila McConnell, M.D., 5530 Wisconsin Avenue, #915, Chevy Chase, Maryland 20815				31. Date filed (Month, Day, Year) JUL 23 1996				32. Registrar's Signature <i>John Davidson-Randall</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

96 23267

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) George Kennedy Gordon				2. DATE OF DEATH MONTH July DAY 22 YEAR 1996				3. TIME OF DEATH 1:14 p. M		
4. SOCIAL SECURITY NUMBER 214-32-8743		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 59 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) October 31, 1936		8. BIRTHPLACE (State or Foreign Country) Maryland		
9a. FACILITY NAME (If not institution, give street and number) St. Mary's Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Leonardtwn			9c. COUNTY OF DEATH St. Mary's			
RESIDENCE OF DECEDENT										
10a. STATE Maryland		10b. COUNTY St. Mary's		10c. CITY, TOWN OR LOCATION Lexington Park				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 54 Lord Calvert Trailer Park				10f. ZIP CODE 20653		10g. CITIZEN OF WHAT COUNTRY? United States				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Custodian			16b. KIND OF BUSINESS/INDUSTRY Public Schools			
17. FATHER'S NAME (First, Middle, Last) Kennedy Francis Gordon				18. MOTHER'S NAME (First, Middle, Maiden Surname) Georgia Anna Milburn						
19a. INFORMANT'S NAME (Type/Print) Carl Nathaniel Gordon, Sr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 54 Lord Calvert Trailer Park, Lexington Park, Maryland 20653						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Charles Memorial Gardens		DATE July 26, 1996		20c. LOCATION — City or Town, State Leonardtwn, Maryland				
21. SIGNATURE OF FUNERAL SERVICE PERSON <i>Michael K. Blankenship</i> Michael K. Blankenship, MO0857				22. NAME AND ADDRESS OF FACILITY Brinsfield Funeral Home, P.A. 59 N. Washington St., Leonardtown, MD 20650-0279						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Probable Myocardial Infarction Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death seconds		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) n/a		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William D. Boyd II</i>				29c. LICENSE NUMBER D14285		29d. DATE SIGNED (Month, Day, Year) July 23, 1996				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William D. Boyd II, M.D., 17 Jefferson Street, Leonardtown, Maryland 20650										
31. DATE FILED (Month, Day, Year) JUL 26 1996		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>								

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23268

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Helen Elliott Gordon				2. Date of Death Month Day Year July 21, 1996		3. Time of Death 4:15 PM	
	4a. Facility Name (If not institution, give street and number) 8112 Riggs Road				4b. City, Town, or Location of Death Adelphi		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 229-18-4109		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 11, 1922	9. Birthplace (State or Foreign Country) Virginia
	Usual Residence of Decedent				10a. State Maryland		10b. County Prince George's	
To Be Completed by Funeral Director	10c. City, Town or Location Adelphi				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 8112 Riggs Road	
	10f. Zip Code 20783				10g. Citizen of What Country? United States		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Executive Secretary		16b. Kind of Business/Industry United States Dept. of Interior	
	17. Father's Name (First, Middle, Last) Willis Melville Elliott				18. Mother's Name (First, Middle, Maiden Surname) Meda Winston Weaver			
	19a. Informant's Name/Relationship (Type, Print) Patricia G. Hollingsworth				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10883 Oak Green Court, Burke, VA 22015			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		20c. Location - City or Town, State 7-22 Beltsville, Maryland	
	21. Signature of Funeral Service Licensee <i>Eileen H. Rapp</i>				22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Colon Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 6 months			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		
28c. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier <i>Martin D. Weltz</i>				29c. License number D23743		29d. Date signed (Month, Day, Year) July 22, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin D. Weltz, M. D., 7525 Greenway Center Drive, Greenbelt, MD 20770				31. Data filed (Month, Day, Year) JUL 23 1996				
32. Registrar's Signature <i>Julia Davidson-Randall</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23269

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Martha Ruby Grandy		2. Date of Death Month Day Year July 24 1996		3. Time of Death 0755A
	4a. Facility Name (If not Institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL		4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY
Funeral Director	5. Social Security Number 279-22-2939	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) July 18, 1911		9. Birthplace (State or Foreign Country) Montgomery		
To Be Completed by Funeral Director	10a. State MD		10b. County Montgomery		10c. City, Town or Location North Potomac
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number 12025 Winesap Terrace		10f. Zip Code 20878		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Own Home
	17. Father's Name (First, Middle, Last) Howard R. Unklesbay		18. Mother's Name (First, Middle, Maiden Surname) Madaline Archer		
	19a. Informant's Name/Relationship (Type, Print) Marlene Rush		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12025 Winesap Terrace, North Potomac, MD 20878		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenwood Cemetery		20c. Location - City or Town, State Byesville, Ohio
	21. Signature of Funeral Service Licensee Steven D. Strand		22. Name and Address of Facility Francis J. Collins Funeral Home, Inc., 500 University Blvd. West Silver Spring, MD 20901		
Physician /Medical Examiner	23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Myocardial infarction Acute Congestive heart failure Severe Dehydration				Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Rheumatoid arthritis				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier Steven D. Strand		29c. License number 022978		29d. Date signed (Month, Day, Year) 7/24/96
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KHIANEY HIRSH, 19520 Doctors Drive Germantown, MD 20874				
State Registrar	31. Date filed (Month, Day, Year) JUL 25 1996		32. Registrar's Signature John A. ...		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

96 23270

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William Francis Hudson				2. DATE OF DEATH MONTH July DAY 28, 1996 YEAR		3. TIME OF DEATH 11:05 A.M.	
4. SOCIAL SECURITY NUMBER 213-34-0416		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 58 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sep 12, 1937	
9a. FACILITY NAME (If not institution, give street and number) 1 Dorsey St., Newtowne Village #101				9b. CITY, TOWN OR LOCATION OF DEATH Leonardtwn		9c. COUNTY OF DEATH St. Mary's	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY St. Mary's		10c. CITY, TOWN OR LOCATION Leonardtwn		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1 Dorsey St. Newrowne Village #101				10f. ZIP CODE 20650		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1955 - 1961		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 2 yrs		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of life. Do NOT use retired.) Electronic Technician		16b. KIND OF BUSINESS/INDUSTRY U.S. Government			
17. FATHER'S NAME (First, Middle, Last) Frank Hudson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Elizabeth Rupprecht			
19a. INFORMANT'S NAME (Type/Print) Ann Marie Hudson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Dorsey St, Newtowne Vlg #101, Leonardtown, MD 20650			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Francis Xavier Cem 7/31/96		20c. LOCATION — City or Town, State Compton, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael K. Gardiner</i>				22. NAME AND ADDRESS OF FACILITY Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Gastric Carcinoma</u>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William Kelly</i>				29c. LICENSE NUMBER A39979		29d. DATE SIGNED (Month, Day, Year) 7/29/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William Kelly, M.D. Leonardtown, MD 20650							
31. DATE FILED (Month, Day, Year) JUL 30 1996				32. REGISTRAR'S SIGNATURE <i>Galia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 23271

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Aileen Lee Hutson				2. DATE OF DEATH MONTH DAY YEAR July 29, 1996				3. TIME OF DEATH 5:20 A. M.	
4. SOCIAL SECURITY NUMBER 530-12-9602		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 23, 1928		8. BIRTHPLACE (State or Foreign Country) West Virginia		
9a. FACILITY NAME (If not institution, give street and number) Charlotte Hall Veterans Home				9b. CITY, TOWN OR LOCATION OF DEATH Charlotte Hall				9c. COUNTY OF DEATH St. Mary's	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY St. Mary's		10c. CITY, TOWN OR LOCATION Leonardtown				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER Star Route Box 70-A				10f. ZIP CODE 20650			10g. CITIZEN OF WHAT COUNTRY? United States		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1951-1954		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Technician			16b. KIND OF BUSINESS/INDUSTRY Navy Defense		
17. FATHER'S NAME (First, Middle, Last) Harry Windell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eva Lowe					
19a. INFORMANT'S NAME (Type/Print) Toy W. Hutson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Star Route Box 70-A, Leonardtown, Maryland 20650					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery 8-5-96		20c. LOCATION — City or Town, State Arlington, Virginia			
21. SIGNATURE OF FUNERAL HOME LICENSEE <i>Michael K. Blankenship</i> Michael K. Blankenship				22. NAME AND ADDRESS OF FACILITY Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiopulmonary arrest</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>Sudden Death</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>possible acute Myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death 4 min	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
		28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. M. E. Lu</i> M.D. 29c. LICENSE NUMBER D46246 29d. DATE SIGNED (Month, Day, Year) July 29, 1996							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. M. E. Lu St. Mary's Hospital Leonardtown MD 20650		31. DATE FILED (Month, Day, Year) JUL 30 1996							
		32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23272

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Bernard Hogan				2. Date of Death Month July Day 21 Year 1996		3. Time of Death 8:20 PM		
	4a. Facility Name (If not institution, give street and number) Montgomery General Hospital				4b. City, Town, or Location of Death Olney		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 212-14-5876		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 14, 1921		
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent 10a. State Maryland 10b. County Montgomery 10c. City, Town or Location Silver Spring 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		11. Merit Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Building	
17. Father's Name (First, Middle, Last) William J. Hogan				18. Mother's Name (First, Middle, Maiden Surname) Maude M. Lucas					
19a. Informant's Name/Relationship (Type, Print) Shirley Hogan / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16204 Old Orchard Road, Silver Spring, Maryland 20905					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Location - City or Town, State Silver Spring, Maryland		20d. Date 7/25/96	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute myocardial infarction Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last End Stage Renal Disease Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death 1 Day	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End Stage Renal Disease								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number 019192	
29d. Date signed (Month, Day, Year) July 22, 1996				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barry Hecht, M.D. 3941 FERRARA DRIVE WHEATON, MD 20906					
31. Date filed (Month, Day, Year) JUL 24 1996				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

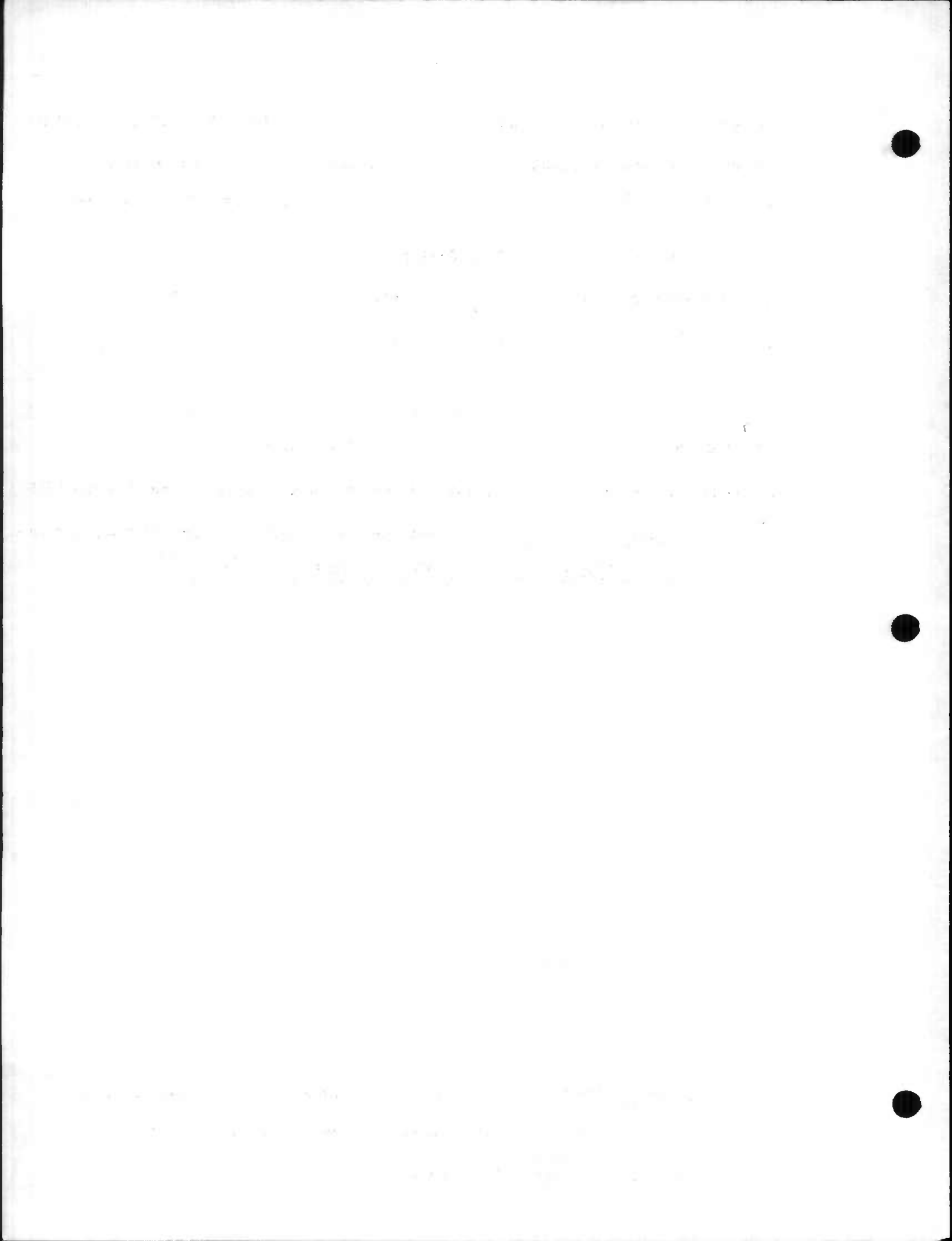
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

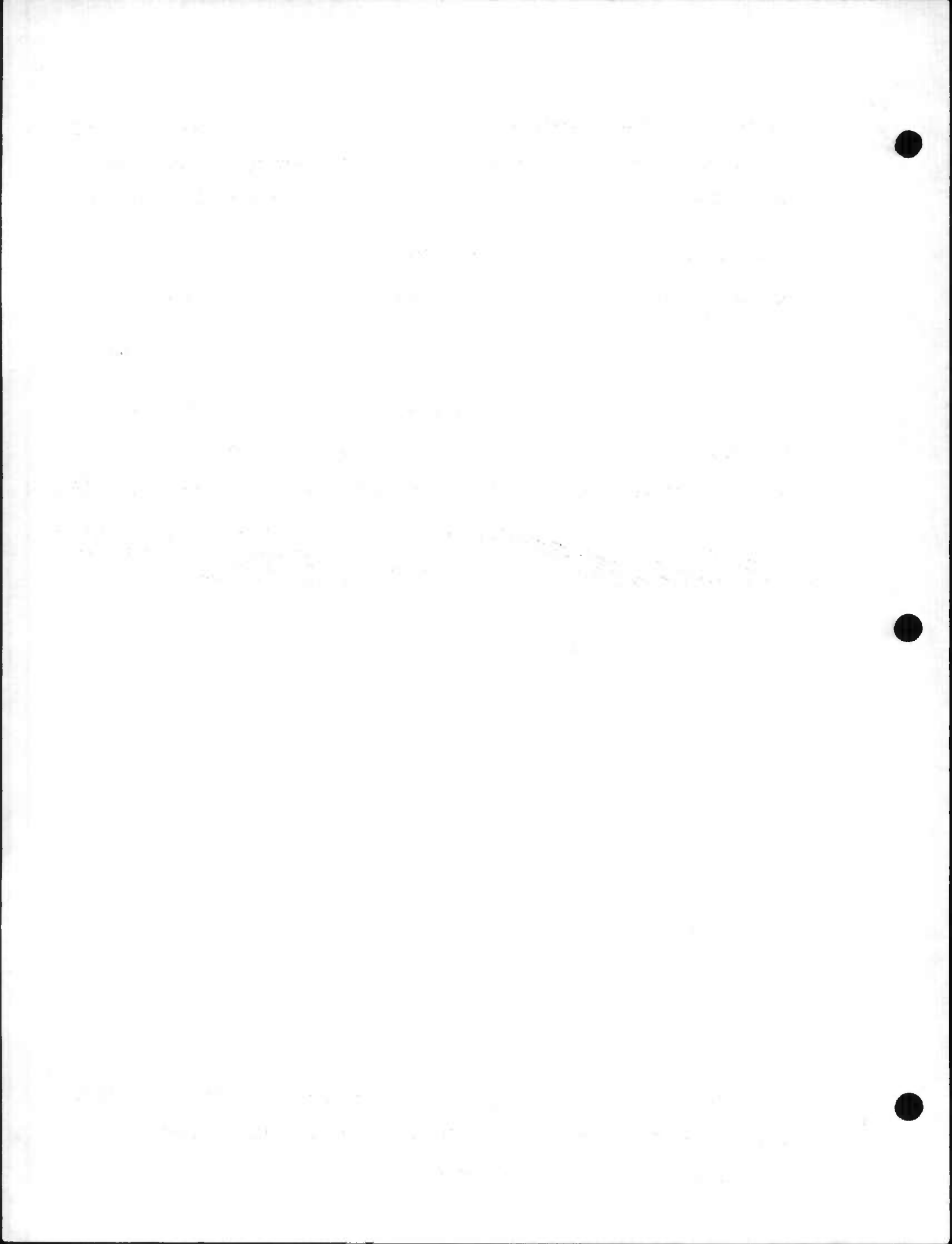
State of Maryland / Department of Health and Mental Hygiene

96 23273

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Phyllis Elaine Hamilton				2. Date of Death Month 7 Day 20 Year 96		3. Time of Death 7:23 P	
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 469-24-0965		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) July 8 1924	
	9. Birthplace (State or Foreign Country) Minnesota		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1005 Orchard Way		10f. Zip Code 20904		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) _____		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) Roy Gregg	
	18. Mother's Name (First, Middle, Maiden Surname) Myrtle Swanson		19a. Informant's Name/Relationship (Type, Print) Henry L. Hamilton / Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15119 New Hampshire Avenue, Silver Spring, Maryland 20905		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park		20c. Date 7/23/96		20d. Location - City or Town, State Rockville, Maryland		21. Signature of Funeral Service Licensee	
	22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. metastatic breast cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 6 years		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	29b. Signature and title of certifier George A. Sotos MD		29c. License number D43083		29d. Date signed (Month, Day, Year) July 21, 1996		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George A. Sotos 9707 Medical Center Dr. Suite 300 Rockville, MD 20850	
State Registrar	31. Date filed (Month, Day, Year) JUL 24 1996		32. Registrar's Signature Julia Davidson-Randall		33. Date of Death (Month, Day, Year) JUL 20 1996		34. Time of Death (Month, Day, Year) JUL 20 1996	



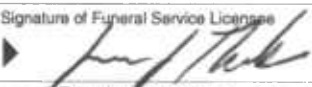
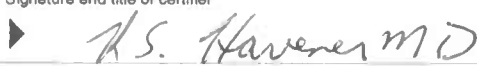
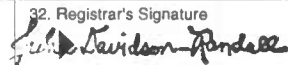
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23274

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Betty F. Haight				2. Date of Death Month Day Year July 12, 1996				3. Time of Death 2:35 P.M.	
	4a. Facility Name (If not institution, give street and number) National Naval Medical Center				4b. City, Town, or Location of Death Bethesda				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 577-26-5803		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 7, 1907		9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent				10a. State MD				10b. County Montgomery	
To Be Completed by Funeral Director	10c. City, Town or Location Bethesda				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	10e. Street and Number 7205 Clarendon Road				10f. Zip Code 20814				10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home	
	17. Father's Name (First, Middle, Last) Joseph Faddock				18. Mother's Name (First, Middle, Maiden Surname) Tillie SMith					
	19a. Informant's Name/Relationship (Type, Print) Mary F. Deetjen- sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7205 Clarendon Rd. Bethesda, Md. 20814					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington Nat'l. Cem. 7/24/96				20c. Location - City or Town, State Arlington, Va.	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., NW Wash., DC 20016					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Upper GI Bleed Due to (or as a consequence of): b. Esophageal varices Due to (or as a consequence of): c. Cirrhosis Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate interval between Onset and Death					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number RES- 000		
29d. Date signed (Month, Day, Year) July 19, 1996				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) National Naval Medical Center Bethesda, Md. 20889-5600						
31. Date filed (Month, Day, Year) JUL 22 1996				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23275

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>MARGARET J. HAFFNER</i>				2. Date of Death Month <i>July</i> Day <i>24</i> Year <i>1996</i>		3. Time of Death <i>4:32 PM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Washington Adventist Hospital</i>				4b. City, Town, or Location of Death <i>Takoma Park</i>		4c. County of Death <i>Montgomery</i>	
Funeral Director	5. Social Security Number <i>579-09-3595</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>80</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Jan. 23, 1916</i>	
	9. Birthplace (State or Foreign Country) <i>Maryland</i>		10a. State <i>MD</i>		10b. County <i>Montgomery</i>		10c. City, Town or Location <i>Silver Spring</i>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <i>413 East Wayne Avenue</i>		10f. Zip Code <i>20901</i>		10g. Citizen of What Country? <i>USA</i>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Clerk</i>		16b. Kind of Business/Industry <i>Government</i>			
	17. Father's Name (First, Middle, Last) <i>Erich Haffner</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Pearl Lawson</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Constance Haffner</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>413 East Wayne Avenue, Silver Spring, MD 20901</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Parklawn Cemetery</i>		20c. Date <i>7/27/96</i>		20d. Location - City or Town, State <i>Rockville, Maryland</i>	
	21. Signature of Funeral Service Licensee <i>William L. Byrd</i>		22. Name and Address of Facility <i>Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901</i>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Pneumonia</i> Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Malnutrition</i> <i>Terminal Renal Failure</i> <i>Parkinson's disease</i>							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>Antonia Lyons</i>				29c. License number <i>D15146</i>		29d. Date signed (Month, Day, Year) <i>7/25/96</i>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>354 University Blvd. W. Silver Spring, Md 20901</i>							
	31. Date filed (Month, Day, Year) <i>JUL 26 1996</i>				32. Registrar's Signature <i>Davidson-Randall</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23276

Amended #1, 6/25/96, MRT, Montg. Cty. **Certificate of Death**

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Camilla G. Haase</u>				2. Date of Death Month <u>July</u> Day <u>23</u> Year <u>96</u>				3. Time of Death <u>1 am</u>						
	4a. Facility Name (If not institution, give street and number) <u>Bedford Court Nursing Home</u>				4b. City, Town, or Location of Death <u>Silver Spring</u>				4c. County of Death <u>Montgomery</u>						
Funeral Director	5. Social Security Number <u>147-16-2660</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>78</u> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.						
	8. Date of Birth (Month, Day, Year) <u>July 9, 1918</u>		9. Birthplace (State or Foreign Country) <u>Pennsylvania</u>		10a. State <u>Maryland</u>		10b. County <u>Montgomery</u>		10c. City, Town or Location <u>Silver Spring</u>						
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <u>3700 International Drive</u>				10f. Zip Code <u>20906</u>		10g. Citizen of What Country? <u>United States</u>						
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <u>World War II</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <u>White</u>						
	15. Decedent's Education (Specify only highest grade completed) <u>Elementary/Secondary (0-12)</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Homemaker</u>				16b. Kind of Business/Industry <u>Own Home</u>						
	17. Father's Name (First, Middle, Last) <u>Charles Clifford Gillette</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Camilla Bunker Reed</u>										
	19a. Informant's Name/Relationship (Type, Print) <u>Camilla B. Haase / daughter</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>88 Park Avenue, #401, Arlington, Massachusetts 02174</u>										
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Montgomery Crematorium, Inc.</u>				20c. Location - City or Town, State <u>Bethesda, Maryland</u>								
	21. Signature of Funeral Service Licensee <u>[Signature]</u> M00831				22. Name and Address of Facility <u>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</u>										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>a. Artherosclerotic Heart Disease</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>b. Chronic Obstructive Pulmonary Disease</u> Due to (or as a consequence of): <u>c. Congestive Heart Failure</u> Due to (or as a consequence of): <u>d.</u>										Approximate Interval Between Onset and Death <u>years</u>				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Chronic Obstructive Pulmonary Disease</u> <u>Congestive Heart Failure</u>										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>D33357</u>		29d. Date signed (Month, Day, Year) <u>7/23/96</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Lee Jonathan Musker was 6320 Democracy Blvd Bethesda MD</u>															
31. Date filed (Month, Day, Year) <u>JUL 25 1996</u>		32. Registrar's Signature <u>[Signature]</u>													

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23277

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MINH CONG HA

2. Date of Death

Month
JulyDay
21Year
1996

3. Time of Death

745 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

574-36-2728

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 2, 1928

9. Birthplace (State or Foreign Country)

Vietnam

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13523 Turkey Branch Parkway

10f. Zip Code

20853

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Asian

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Draftsman

16b. Kind of Business/Industry

Architecture

17. Father's Name (First, Middle, Last)

Hoai H. Ha

18. Mother's Name (First, Middle, Maiden Surname)

Diep Nguyen

19a. Informant's Name/Relationship (Type, Print)

Minhthu Ha

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12005 Cheyenne Road, Gaithersburg, MD 20878

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory 07/27/96 Alexandria, Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

John L. Chupak

22. Name and Address of Facility Francis J. Collins
Funeral Home, Inc. 500 University Blvd. West
Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, aneurysm failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Gastrointestinal hemorrhage

Due to (or as a consequence of):

b. Immune Thrombocytopenic Purpura

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicidal
4 ☐ Homicide 5 ☐ Pending
Investigation 6 ☐ Could not be
determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Peter B. Sherer MD

29c. License number

021910

29d. Date signed (Month, Day, Year)

July 21, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter B. Sherer MD 3947 Ferrara Dr. Wheaton, MD 20906

31. Date filed (Month, Day, Year)

JUL 23 1996

32. Registrar's Signature

Julie Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23278

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mabel Hardy Hobbs

2. Date of Death

Month
JulyDay
23Year
1996

3. Time of Death

12:00 am

4a. Facility Name (If not institution, give street and number)

Randolph Hill Nursing Home

4b. City, Town, or Location of Death

Wheaton

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

227-09-2831

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Sept. 2, 1904

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Wheaton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4001 Randolph Road

10f. Zip Code

20902

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Jesse Robert Hardy

18. Mother's Name (First, Middle, Maiden Surname)

Annie Owen

19a. Informant's Name/Relationship (Type, Print)

Dorothy H. Sowell

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1260 Andover Road Charlotte, NC 28211

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Highland Memorial Park 7/26/96 Danville, Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins
Funeral Home, Inc 500 University Blvd. West
Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Myocardial Infarction

Approximate
Interval Between
Onset and Death

6 Hours

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of injury
(Month, Day, Year)28b. Time of
injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D09834

29d. Date signed (Month, Day, Year)

July 23, 1996

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Barry N. Rosenbaum, M.D. 3720 Farragut Avenue Kensington, MD 20895-2110

31. Date filed (Month, Day, Year)

JUL 23 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

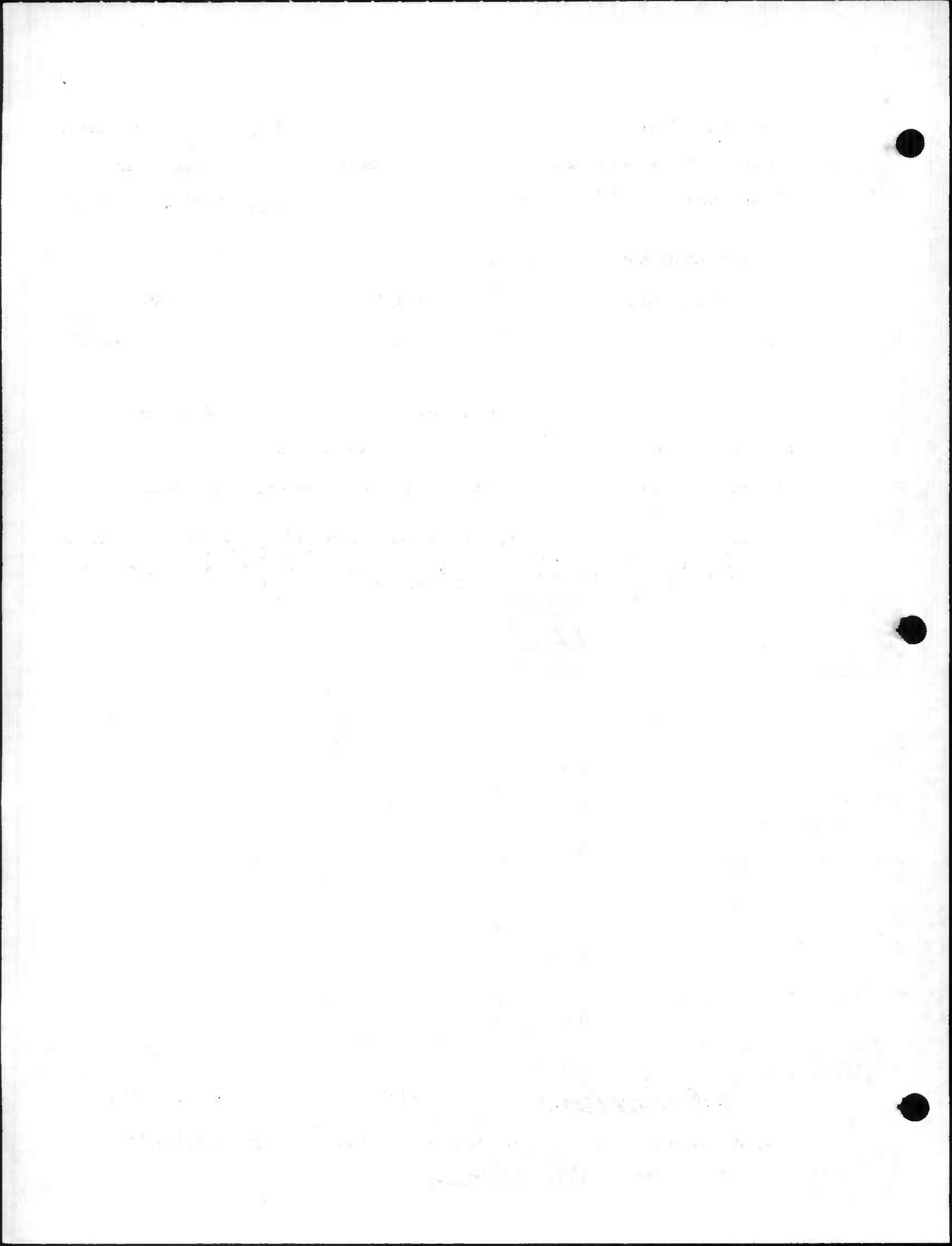
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

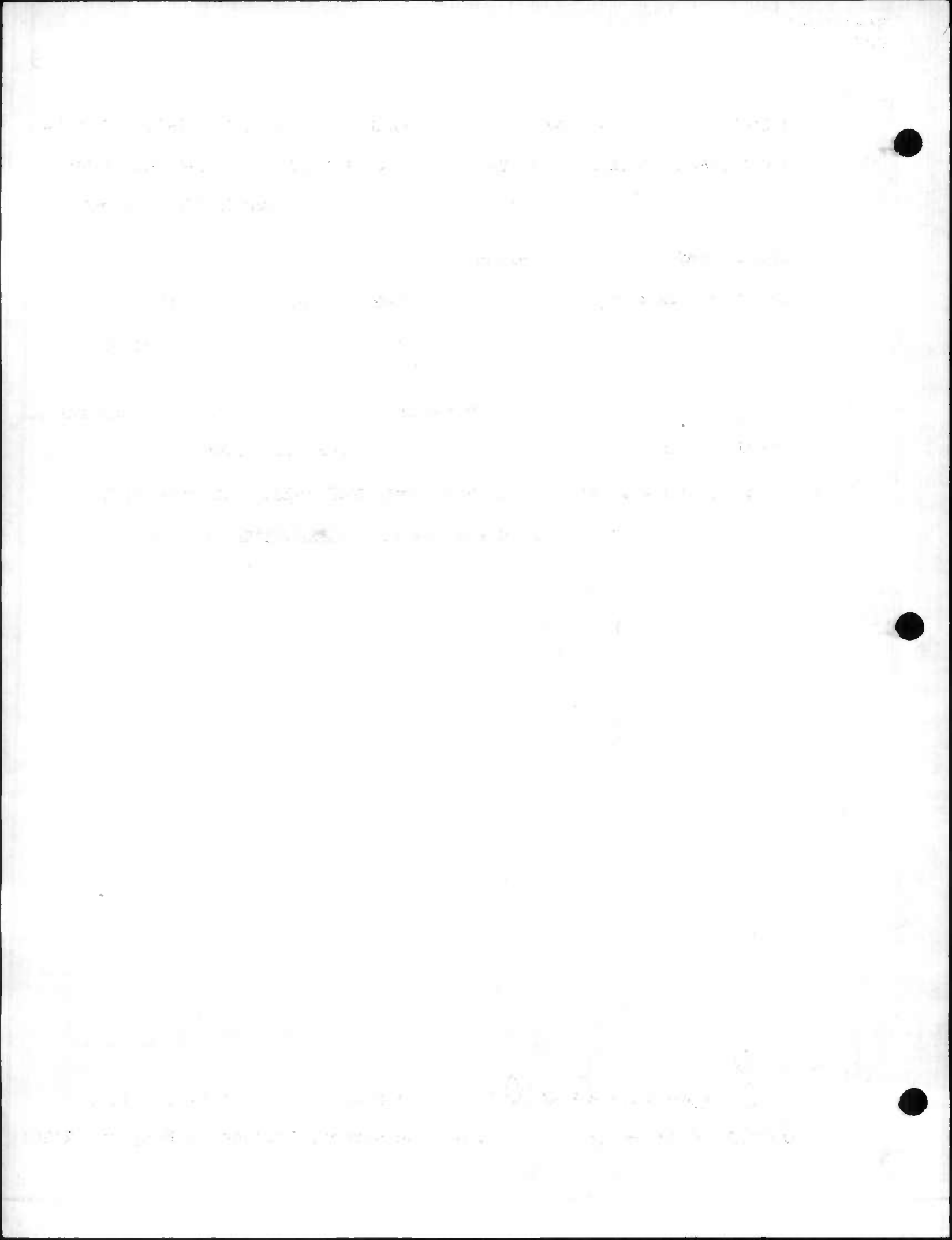
State of Maryland / Department of Health and Mental Hygiene

96 23279

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DERRICK ADRIAN HALL		2. Date of Death Month Day Year JULY 19, 1996		3. Time of Death 0245AM
	4a. Facility Name (If not institution, give street and number) PHYSICIANS MEMORIAL HOSPITAL		4b. City, Town, or Location of Death LA PLATA		4c. County of Death CHARLES COUNTY
Funeral Director	5. Social Security Number 212-98-5344	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 26 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) January 1, 1970		9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	10a. State Maryland		10b. County Charles		10c. City, Town or Location Waldorf
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number 3060 Heathcote Road		10f. Zip Code 20602		10g. Citizen of What Country? USA
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic		16b. Kind of Business/Industry Toye's Automotive
	17. Father's Name (First, Middle, Last) Samuel C. Hall		18. Mother's Name (First, Middle, Maiden Surname) Sandra E. Brooks		
	19a. Informant's Name/Relationship (Type, Print) Sandra E. Hall - Mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3060 Heathcote Road, Waldorf, Maryland 20602		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Thomas Cemetery		20c. Location - City or Town, State July 25, 1996 Sandywine, Maryland
	21. Signature of Funeral Service Licensee Lloyd M. Estep		22. Name and Address of Facility Adams Funeral Home, Aquasco, Maryland 20608		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cerebral thrombosis to chest				Approximate Interval Between Onset and Death
	23b. Due to (or as a consequence of): a. Cerebral thrombosis to chest b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 7-19-96		28b. Time of Injury 0151 M
			28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject shot
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET		28f. Location (Street and Number or Rural Route Number, City or Town, State) Rt 225 and 224
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier Carolalems		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 19, 1996
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JARON LOPEZ, MD 111 Penn Street, Baltimore, Maryland 21201				
31. Date filed (Month, Day, Year) JUL 26 1996		32. Registrar's Signature Julia Anderson-Randall			





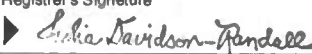
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23280

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Doris Alverta Hall		2. Date of Death Month July Day 19 Year 1996		3. Time of Death 1238
	4e. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO
Funeral Director	5. Social Security Number 213-22-6118	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) May 27, 1927		9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State Maryland	10b. County Worcester	10c. City, Town or Location Pocomoke		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 1913 Cedar Hall Road		10f. Zip Code 21851		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurses Aide		16b. Kind of Business/Industry Nursing		
	17. Father's Name (First, Middle, Last) Charlie Merrill		18. Mother's Name (First, Middle, Maiden Surname) Stella Teagle		
	19a. Informant's Name/Relationship (Type, Print) Antonia Hall		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1813 Pitt Circle Road, Pocomoke, Md. 21851		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. James U.M. Church Ce		20c. Location - City or Town, State 7/26/96 Pocomoke, Md.
	21. Signature of Funeral Service to be used 		22. Name and Address of Facility Bennie Smith Funeral Home P.O. Box 1687, Easton, Md. 21601		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE CARDIOMYOPATHY Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL INSUFFICIENCY COPD					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier  M.D.		29c. License number D29168		29d. Date signed (Month, Day, Year) 7/19/96	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Robert Ballen MD 560 Riverside Dr A204 Salisbury Md. 21801					
31. Date filed (Month, Day, Year) JUL 26 1996		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 23281

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Catherine Virginia Jones				2. DATE OF DEATH MONTH DAY YEAR July 21, 1996				3. TIME OF DEATH 7:58 A M	
4. SOCIAL SECURITY NUMBER 214-28-7660		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH MONTH DAY YEAR Jun 8, 1916		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) White Neck Road				9b. CITY, TOWN OR LOCATION OF DEATH Bushwood				9c. COUNTY OF DEATH St. Mary's	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY St. Mary's		10c. CITY, TOWN OR LOCATION Bushwood				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER Box 68				10f. ZIP CODE 20618				10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 years				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Extension Agent				16b. KIND OF BUSINESS/INDUSTRY University of Maryland	
17. FATHER'S NAME (First, Middle, Last) Thomas Marion Turner				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Viola Turner					
19a. INFORMANT'S NAME (Type/Print) Joseph Gibson, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38459 Ole Trappe Lane, Avenue, MD 20609					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Christ Episcopal Cemetery 7/24/96 Chaptico. MD				20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael A. Gindine</i>				22. NAME AND ADDRESS OF FACILITY Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Probable Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate interval Between Onset and Death —	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) UNATTENDED					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William D. Boyd, II, M.D.</i>						29c. LICENSE NUMBER 014285		29d. DATE SIGNED (Month, Day, Year) 7-22-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William D. Boyd, II, M.D. Leonardtown, Maryland 20650									
31. DATE FILED (Month, Day, Year) JUL 23 1996				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23282

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Daniel Jaspan

2. Date of Death

Month
JulyDay
23Year
96

3. Time of Death

7:30 AM

4a. Facility Name (If not institution, give street and number)

Manor Care - Bethesda

4b. City, Town, or Location of Death

Chevy Chase

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

210-30-3887

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 6, 1906

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8100 Connecticut Avenue, Apt. 408

10f. Zip Code

20815

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Legislative Representative

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

David Jaspan

18. Mother's Name (First, Middle, Maiden Surname)

Maggie Comroe

19a. Informant's Name/Relationship (Type, Print)

Arlene S. Edney

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

709 Kerwin Road, Silver Spring, MD 20901

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory 7/24/96 Alexandria, Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins
Funeral Home, Inc. 500 University Blvd. West
Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Renal Failure

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and Title of certifier

29c. License number

D33357

29d. Date signed (Month, Day, Year)

7/20/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lee Jonathan Musher in 6320 Democracy Blvd Beth in

31. Date filed (Month, Day, Year)

JUL 24 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23283

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALVERN JACKSON				2. Date of Death Month JUNE Day 23 Year 1996				3. Time of Death 7:23 PM	
	4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL				4b. City, Town, or Location of Death SILVER SPRING				4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 259 26 0917		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) 71 Yrs.		8. Date of Birth Month FEB. Day 2 Year 1925		9. Birthplace (State or Foreign Country) GEORGIA	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD.		10b. County PRINCE GEORGES		10c. City, Town or Location ADELPHI				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 1801 METZEROTT RD.				10f. Zip Code 20783		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		Collage (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) UNKNOWN			16b. Kind of Business/Industry UNKNOWN		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) UNKNOWN				18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN					
	19a. Informant's Name/Relationship (Type, Print) ROSEMARY MADDEN				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5101 RHODE ISLAND AVE. HYATTSVILLE, MD 20781					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 6/27/96		20c. Location - City or Town, State Alexandria, Va			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility TAKOMA FUNERAL HOME INC 254 CARROLL ST N.W. WASHINGTON, D.C. 20012							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SEPSIS								Approximate Interval Between Onset and Death 24 hrs.	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
	Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEHYDRATION									
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier 				29c. License number D06674		29d. Date signed (Month, Day, Year) 6/26/96			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MYRON I. LENKIN, M.D. 2309 SHOREFIELD DRIVE, WHEATON, MD. 20902									
State Registrar	31. Date filed (Month, Day, Year) JUL 25 1996				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23284

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BEN B. KALSER

2. Date of Death

Month Day Year
July 18 1996 03:30

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY CTY, MD

5. Social Security Number

192-18-9101

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 1, 1924

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6012 Rossmore Dr.

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager Analyst

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Max Kalser

18. Mother's Name (First, Middle, Maiden Surname)

Rose Sulkis

19a. Informant's Name/Relationship (Type, Print)

Sarah Kalser

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6012 Rossmore Dr.; Bethesda, MD 20814

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Anshe Neisen Cemetery

Date

7/21

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensed

22. Name and Address of Facility

Edward Sagel Funeral Direction

1091 Rockville Pike Rockville MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Abdominal Aortic Aneurysm
Due to (or as a consequence of):

Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Richard L. Feinberg, MD

29c. License number

D 42865

29d. Date signed (Month, Day, Year)

7/18/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RICHARD L. FEINBERG, M.D. 8218 WISC. AVE, #204 BETHESDA, MD.

31. Date filed (Month, Day, Year)

JUL 24 1996

32. Registrar's Signature

Julia Davidson-Rodriguez

State
Registrar

Baltimore, Maryland 21215-0020

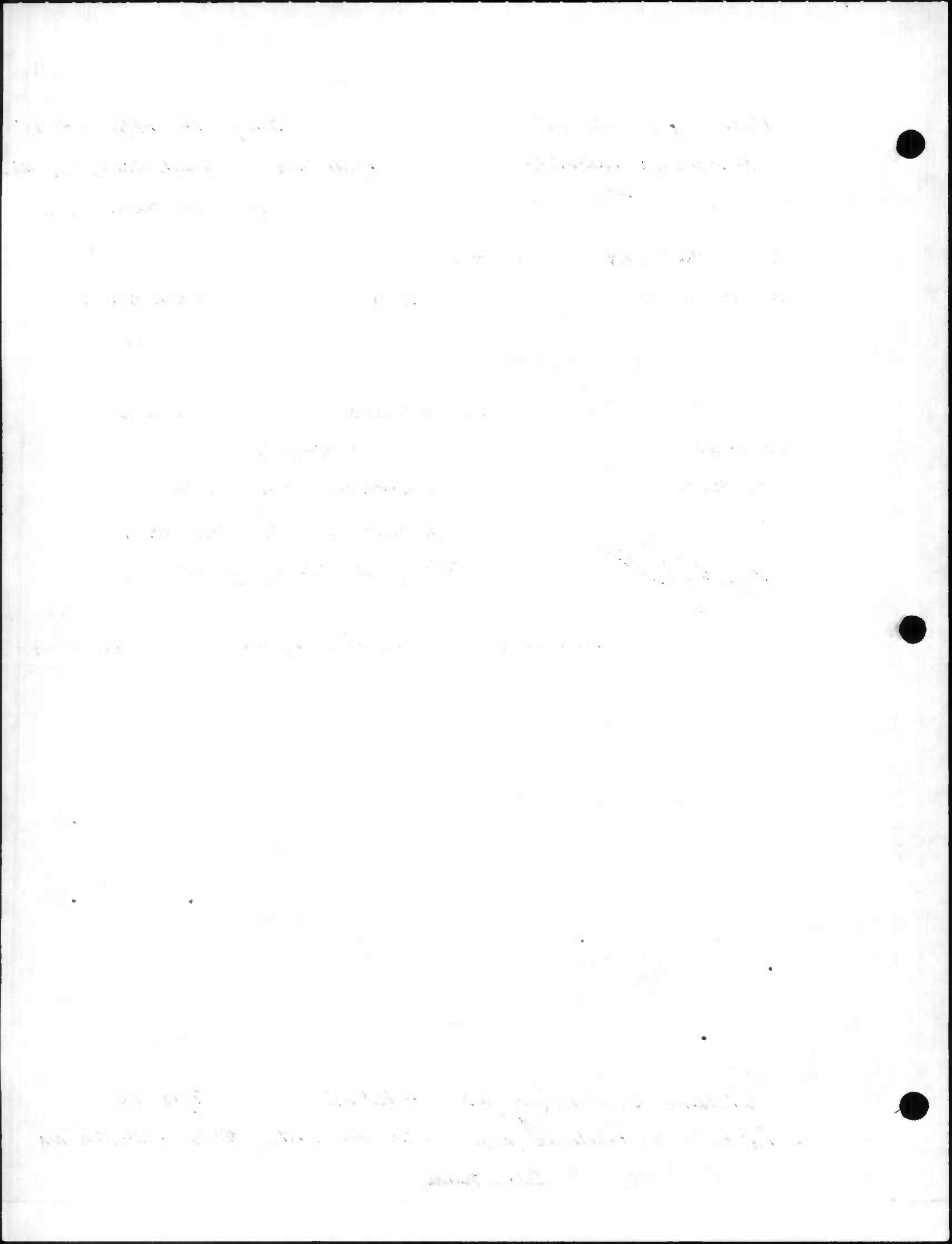
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



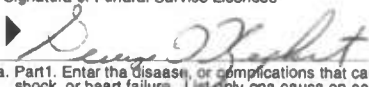

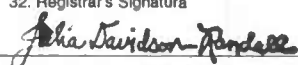
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23285

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Martha Smith Kimble				2. Date of Death Month Day Year July 18, 1996				3. Time of Death 19:45	
	4a. Facility Name (If not institution, give street and number) 3800 Club Drive				4b. City, Town, or Location of Death Chevy Chase				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 578-12-1848		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 24, 1916		9. Birthplace (State or Foreign Country) South Carolina	
	10a. State Maryland				10b. County Montgomery		10c. City, Town or Location Chevy Chase		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 3800 Club Drive				10f. Zip Code 20815		10g. Citizen of What Country? United States			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home	
	17. Father's Name (First, Middle, Last) Unknown				18. Mother's Name (First, Middle, Maiden Surname) Unknown					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) James Kimble/ Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 136 North Galveston Street Arlington, Virginia 22203					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium Inc.		20c. Location - City or Town, State Bethesda, Maryland		20d. Date July 20, 1996	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee  M00335				22. Name and Address of Facility Robert A. Humphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. Cardiac Arrest Due to (or as a consequence of): b. Probable Myocardial Infarction Due to (or as a consequence of): c. Vascular Disease Due to (or as a consequence of): d. _____				Approximate Interval Between Onset and Death Seconds Years					
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how Injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number D-23556	
	29d. Date signed (Month, Day, Year) July 19, 1996									
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Blee M.D. 5530 Wisconsin Avenue #1400 Chevy Chase, Maryland 20815									
	31. Date filed (Month, Day, Year) JUL 23 1996				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23286

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Albert C. Kolbye, Jr.				2. Date of Death Month Day Year July 19, 1996				3. Time of Death 5:10 A.M.					
	4a. Facility Name (If not institution, give street and number) 7313 Helmsdale Road				4b. City, Town, or Location of Death Bethesda				4c. County of Death Montgomery					
Funeral Director	5. Social Security Number 028-30-8739		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) 61 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) Feb. 15, 1935		9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Bethesda				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	10e. Street and Number 7313 Helmsdale Road				10f. Zip Code 20817				10g. Citizen of What Country? United States					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Physician/Attorney				16b. Kind of Business/Industry United States Public Health Service					
	17. Father's Name (First, Middle, Last) Albert C. Kolbye, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Marion Bozorth									
	19a. Informant's Name/Relationship (Type, Print) Lise Kolbye/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7313 Helmsdale Road, Bethesda, Maryland 20817									
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.				20c. Location - City or Town, State Bethesda, Maryland					
	21. Signature of Funeral Service Licensee  M00198				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501				Bethesda-Chevy Chase, Inc.					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory Arrest Dua to (or as a consequence of): Hepatic Failure End Stage Cirrhosis Alcoholism Approximate interval between Onset and Death 10 minutes 2 months 6 months >10 Years													
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.													
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown														
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)														
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Could not be determined														
28a. Date of injury (Month, Day Year)														
28b. Time of Injury M														
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
28d. Describe how injury occurred														
28e. Location (Street and Number or Rural Route Number, City or Town, State)														
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
29b. Signature and title of certifier 														
29c. License number D23540														
29d. Date signed (Month, Day, Year) July 19, 1996														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hugh Hill, M.D. 1450 Research Blvd. #310, Rockville, Maryland 20850														
31. Date filed (Month, Day, Year) JUL 23 1996														
32. Registrar's Signature 														

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

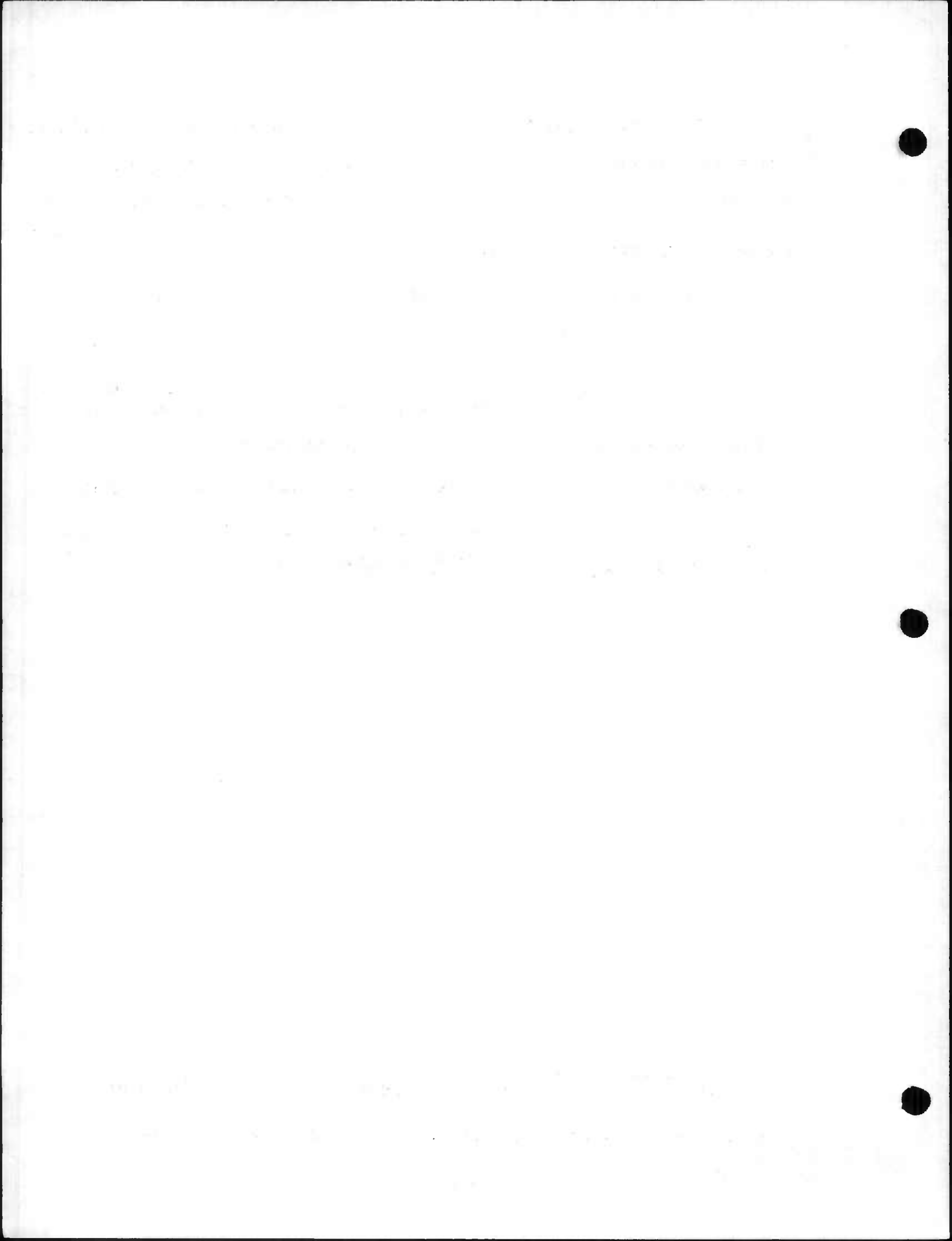
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23287

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Evelyn Florence Kelley				2. Date of Death Month Day Year July 17, 1996		3. Time of Death 11:15 PM	
	4a. Facility Name (If not institution, give street and number) 4809 Camelot Street				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 577-38-4804	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 5, 1914		9. Birthplace (State or Foreign Country) Washington, DC
	Usual Residence of Decedent							
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 4809 Camelot Street				10f. Zip Code 20853		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cafeteria Worker		16b. Kind of Business/Industry Montgomery County Public Schools		
17. Father's Name (First, Middle, Last) Ernest L. Kidwell				18. Mother's Name (First, Middle, Maiden Surname) Anna Alling				
19a. Informant's Name/Relationship (Type, Print) Robert Glenn Kelley/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4809 Camelot Street, Rockville, Maryland 20853				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		Date July 20, 1996		20c. Location - City or Town, State Silver Spring, Maryland		
21. Signature of Funeral Service Licensee Michelle P. Kitta M00348		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 W. Montgomery Avenue, Rockville, Maryland 20850-2805						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cervical Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 3 months
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Rectal Cancer						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Peter B. Sherer MD				29c. License number D21910		29d. Date signed (Month, Day, Year) July 18, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter Sherer, M.D., 3411 Olandwood Court #105, Olney, Maryland 20832								
31. Date filed (Month, Day, Year) JUL 23 1996		32. Registrar's Signature Leta Davidson-Randall						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State Registrar

96 23288

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mohammad Salim Khan				2. DATE OF DEATH MONTH DAY YEAR July 20 1996		3. TIME OF DEATH 4:00 P M	
4. SOCIAL SECURITY NUMBER 578-46-6091		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 26, 1926	
9a. FACILITY NAME (If not institution, give street and number) Western Maryland Hospital Ctr.		9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown				9c. COUNTY OF DEATH Washington	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8910 Woodland Drive				10f. ZIP CODE 20910		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Economist		16. KIND OF BUSINESS/INDUSTRY International Monetary Fund			
17. FATHER'S NAME (First, Middle, Last) Mohammad N. Khan				18. MOTHER'S NAME (First, Middle, Maiden Surname) Amtul Rasheeda			
19a. INFORMANT'S NAME (Type/Print) Tarek Khan				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1128 Spotswood Drive Silver Spring, Md. 20905			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) George Washington Cemetery 7/22		20c. LOCATION — City or Town, State Adelphi Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas Gregor				22. NAME AND ADDRESS OF FACILITY Hines/Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, Md.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Cardiac arrest</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Degenerative Cerebellar Disease</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Respiratory Failure, Ventilator dep.</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>Insulin Dependent Diabetes Mellitus</i>					
Approximate interval Between Onset and Death		immediate 4 yrs 4 yrs Unknown					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i> <i>Hypothyroid</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Davidson</i> MD				29c. LICENSE NUMBER 21742		29d. DATE SIGNED (Month, Day, Year) 7/20 96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 19414 - C Heidersberg Pike Hagerstown MD 21742							
31. DATE FILED (Month, Day, Year) JUL 24 1996		32. REGISTRAR'S SIGNATURE <i>John Davidson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


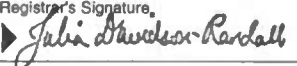
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23289

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Katherine June Kline				2. Date of Death Month Day Year July 22, 1996		3. Time of Death 1:55 p.m.	
	4e. Facility Name (If not institution, give street and number) 401 Blair Road				4b. City, Town, or Location of Death Indian Head		4c. County of Death Charles	
Funeral Director	5. Social Security Number 454-20-1859		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) February 18, 1922	
	9. Birthplace (State or Foreign Country) Texas		10e. State Maryland		10b. County Charles		10c. City, Town or Location Indian Head	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 401 Blair Road			
	10f. Zip Code 20640				10g. Citizen of What Country? U.S.A.			
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Secretary		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry U.S. Government			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Unknown				18. Mother's Name (First, Middle, Maiden Surname) LuLa Luce			
	19a. Informant's Name/Relationship (Type, Print) Leon Kline Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date July 23, 1996		20c. Location - City or Town, State Alexandria, Virginia	
	21. Signature of Funeral Service Licensed  M00668		22. Name and Address of Facility Williams Funeral Home, P.A.					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter conditions such as heart failure, shock, or heart failure. List only one cause on each line. Lung Cancer						Approximate Interval Between Onset and Death 1 yr	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier  Dr. Krishan Mathur		29c. License number D 28352		29d. Date signed (Month, Day, Year) July 23, 1996			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (item 23a) (Type, Print) Dr. Krishan Mathur P.O. Box 2729 LaPlata, MD. 20646							
	31. Date filed (Month, Day, Year) JUL 26 1996		32. Registrar's Signature  Julia Davidson-Randall					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

96 23290

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rosalie Dill Kirby					2. Date of Death Month July Day 21 Year 1996			3. Time of Death 7:45AM	
	4a. Facility Name (If not institution, give street and number) William Hill HCC-Cambridge					4b. City, Town, or Location of Death CAMBRIDGE			4c. County of Death DORCHESTER	
Funeral Director	5. Social Security Number 217-05-2585		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAY 3, 1916		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent									
10a. State MD		10b. County DORCHESTER		10c. City, Town or Location CAMBRIDGE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 525 GLENBURN AVENUE					10f. Zip Code 21613		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BOOKKEEPER				16b. Kind of Business/Industry EASTON UTILITIES			
17. Father's Name (First, Middle, Last) THOMAS DILL					18. Mother's Name (First, Middle, Maiden Surname) DELLA DAVIS					
19a. Informant's Name/Relationship (Type, Print) SHERRY LeCATES /NIECE					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29505 HAWKES HILL ROAD, EASTON, MD 21601					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) WOODLAWN MEMORIAL PARK 7-24 EASTON, MD			Data		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee JOHN R. MERLERO					22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 200 S. HARRISON ST., EASTON, MD 21601					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. ASCVD</p> <p>b. CHF</p> <p>c. COPD</p> <p>d. CRF</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> <p>years</p> </div> </div> <p>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Mary Ann Moore					29c. License number D31766		29d. Date signed (Month, Day, Year) 7-22-96			
30. Name and address of person who completed cause of death (item 23a) (Type, Print) Mary Ann Moore MD 408 Byrn St Cambridge Md. 21613										
31. Date filed (Month, Day, Year) JUL 23 1996					32. Registrar's Signature Lelia Davidson-Randall					

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Physician
/Medical
Examiner

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Division of Vital Records, P.O. Box 68760,
 Baltimore, Maryland 21215-0020


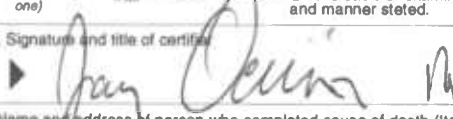
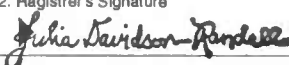
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23291

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Novella Latimore				2. Date of Death Month July Day 14 Year 1996				3. Time of Death 4:50am	
	4a. Facility Name (If not Institution, give street and number) Allegis of Southern Maryland				4b. City, Town, or Location of Death Clinton				4c. County of Death Prince George	
Funeral Director	5. Social Security Number 578-44-1454		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Jan. 12, 1922		9. Birthplace (State or Foreign Country) Virginia		10a. State Md.		10b. County Prince George		10c. City, Town or Location Clinton	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 6803 Clinton Manor Drive		10f. Zip Code 20735		10g. Citizen of What Country? United States		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) Collega (1-4 or 5+)		16. Kind of Business/Industry PVT.	
	17. Father's Name (First, Middle, Last) Albert Munford		18. Mother's Name (First, Middle, Maiden Surname) Grace Lang		19. Informant's Name/Relationship (Type, Print) Curtis Latimore (Son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6803 Clinton Manor Drive, Clinton, Md. 20735		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
	20b. Place of Disposition (Name of cemetery, crematory or other place) Quantico National		20c. Location - City or Town, State Triangle, Va.		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility R. N. Horton Co. Morticians, Inc. 600 Kennedy Street, N. W., Wash., DC		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Coronary Artery Disease Due to (or as a consequence of): Renal failure Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D2195S	
	29d. Date signed (Month, Day, Year) 7/16/96		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Jay Ocun, M.D. 106 Irving Street, N. W., Wash., D. C. 20001		31. Date filed (Month, Day, Year) JUL 22 1996		32. Registrar's Signature 		State Registrar	

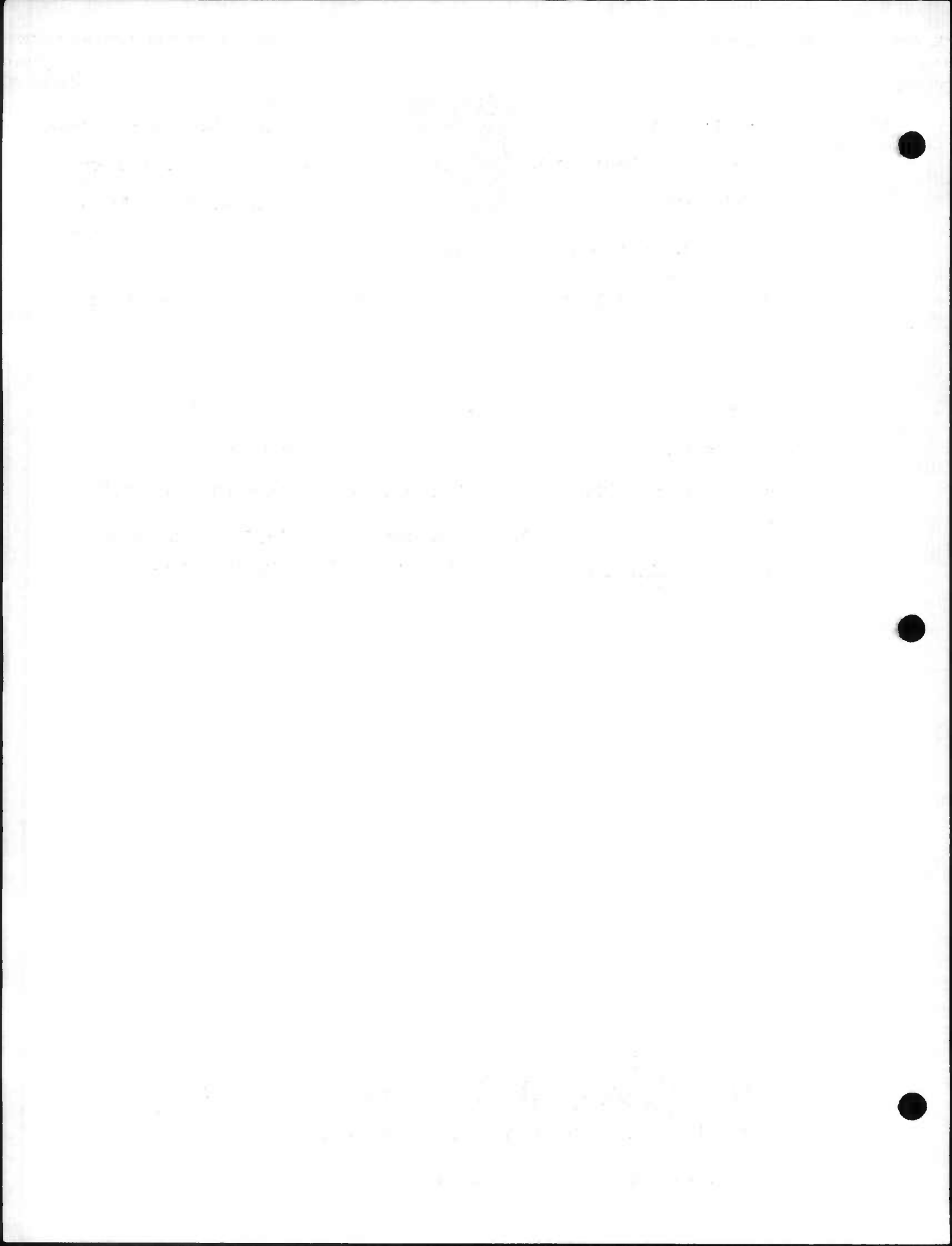
Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23292

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph John Loftus, Sr.				2. Date of Death Month Day Year July 20 1996				3. Time of Death 7:51 AM													
	4a. Facility Name (If not institution, give street and number) 13720 Lionel Lane				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery													
Funeral Director	5. Social Security Number 165-20-7770		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 10, 1928		9. Birthplace (State or Foreign Country) Pennsylvania													
	Usual Residence of Decedent																					
To Be Completed by Funeral Director	10a. State MD		10b. County Montgomery		10c. City, Town or Location Rockville				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
	10e. Street and Number 13720 Lionel Lane				10f. Zip Code 20853		10g. Citizen of What Country? USA															
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1946-48		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White														
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)				18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chemist			16b. Kind of Business/Industry Federal Government														
	17. Father's Name (First, Middle, Last) John Joseph Loftus				18. Mother's Name (First, Middle, Maiden Surname) Mary Cecilia McHale																	
	19a. Informant's Name/Relationship (Type, Print) Adeline D. Loftus				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13720 Lionel Lane, Rockville, MD 20853																	
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		Date 7/25/96		20c. Location - City or Town, State Silver Spring, Maryland															
	21. Signature of Funeral Service Licensee Robert Ramsey				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc., 500 University Blvd. West Silver Spring, MD 20901																	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																					
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Hemoperitoneum</td> <td>Approximate Interval Between Onset and Death 3 hours</td> </tr> <tr> <td>b.</td> <td>Bleeding from bile duct vessels</td> <td>3 hours</td> </tr> <tr> <td>c.</td> <td>Cholecystectomy and ERCP</td> <td>10 days</td> </tr> <tr> <td>d.</td> <td>Chronic cholecystitis with cholelithiasis</td> <td>months</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a.	Hemoperitoneum	Approximate Interval Between Onset and Death 3 hours	b.	Bleeding from bile duct vessels	3 hours	c.	Cholecystectomy and ERCP	10 days	d.	Chronic cholecystitis with cholelithiasis
Immediate Cause (Final disease or condition resulting in death)	a.	Hemoperitoneum	Approximate Interval Between Onset and Death 3 hours																			
	b.	Bleeding from bile duct vessels	3 hours																			
	c.	Cholecystectomy and ERCP	10 days																			
	d.	Chronic cholecystitis with cholelithiasis	months																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Postop bile leak																						
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																						
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																						
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																						
28. Piece of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined																						
28a. Date of Injury (Month, Day, Year)																						
28b. Time of Injury M																						
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																						
28d. Describe how injury occurred																						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																						
28f. Location (Street and Number or Rural Route Number, City or Town, State)																						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																						
29b. Signature and title of certifier Julian T Coaggin, MD Pathologist																						
29c. License number D29538																						
29d. Date signed (Month, Day, Year) July 23, 1996																						
30. Name and address of person who completed cause of death (item 23a) (Type, Print) Julian T Coaggin, MD Montgomery General Hospital Olney, Md																						
31. Date filed (Month, Day, Year) JUL 24 1996																						
32. Registrar's Signature Davidson-Randall																						

Baltimore, Maryland 21215-0020

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Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 23293

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DORSEY EDWARD LANE				2. Date of Death Month JULY Day 19 Year 1996		3. Time of Death 1:25PM	
	4a. Facility Name (If not institution, give street and number) 3621 BANQUO DRIVE				4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 578 52 6175		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) August 11, 1917	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) Washington, D.C.		10a. State Maryland		10b. County Montgomery	
To Be Completed by Funeral Director	10c. City, Town or Location Silver Spring		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 3621 Banquo Dr.		10f. Zip Code 20906	
	10g. Citizen of What Country? United States		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1942		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
To Be Completed by Physician/Medical Examiner	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Attorney		16b. Kind of Business/Industry Howard University	
	17. Father's Name (First, Middle, Last) William Lane		18. Mother's Name (First, Middle, Maiden Surname) Deborah Woods		19a. Informant's Name/Relationship (Type, Print) Michael Lane		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1334 Locust RD., N.W., Washington, D.C. 20012	
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park 7/26/96		20c. Location - City or Town, State Landover, Maryland		21. Signature of Funeral Service Licensed <i>McGuire Funeral Service Inc.</i>	
	22. Name and Address of Facility McGuire Funeral Service Inc. 7400 Georgia Ave., N.W., Washington, D.C. 20012		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. <i>Arteriosclerotic cardiovascular disease</i> Due to (or as a consequence of): b. <i>complicated by drowning</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Division of Vital Records, P.O. Box 68760,	24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year) Found 7-19-96		28b. Time of Injury 115 P M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred Subject Drowned in Bath Tub	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home		28f. Location (Street and Number or Rural Route Number, City or Town, State) 3621 Banquo Rd Montgomery County		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Margie Marshall</i>	
	29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) JULY 20, 1996		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARSHALL A. KORON MD 111 Penn Street, Baltimore, Maryland 21201		31. Date filed (Month, Day, Year) JUL 24 1996	
State Registrar	32. Registrar's Signature <i>John Davidson-Randall</i>		33. Date of Death (Month, Day, Year) JULY 20, 1996		34. Date of Death (Month, Day, Year) JULY 20, 1996		35. Date of Death (Month, Day, Year) JULY 20, 1996	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23294

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Larry D. Lee				2. Date of Death Month July Day 18 Year 1996		3. Time of Death 1052	
	4a. Facility Name (If not institution, give street and number) Anne Arundel General Hospital				4b. City, Town, or Location of Death Annapolis		4c. County of Death AA	
Funeral Director	5. Social Security Number 219-60-0062		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 42 Yrs.		8. Date of Birth (Month, Day, Year) June 29, 1954	
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent 10a. State Maryland 10b. County Dorchester 10c. City, Town or Location Cambridge		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Postal Carrier		16b. Kind of Business/Industry U.S. Postal Services				
17. Father's Name (First, Middle, Last) Levin Lee				18. Mother's Name (First, Middle, Maiden Surname) Alice Robinson Lee				
19a. Informant's Name/Relationship (Type, Print) Myranell Dockins Lee				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 Rigby Avenue, Cambridge, Md. 21613				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Vetran's Cem.		20c. Date 7/23/96		20d. Location - City or Town, State Beulah, Md.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Bennie Smith Funeral Home P.O. Box 1687, Easton, Md. 21601				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Squamous Cell Carcinoma, Lung Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death Unk
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Deputy				29c. License number D 06054		29d. Date signed (Month, Day, Year) July 19, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William P. Jones, M.D. 695 America Court Davidsonville, MD 21035								
31. Date filed (Month, Day, Year) JUL 24 1996		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, a comparison of the results with previous research, and a conclusion about the significance of the study.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the practical applications of the findings, a discussion of the limitations of the study, and a discussion of the directions for future research.

5. The fifth part of the report is a summary of the study. It includes a brief overview of the main findings and a final conclusion about the significance of the study.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Margaret Mary McMahon				2. DATE OF DEATH MONTH July DAY 22 YEAR 1996		3. TIME OF DEATH 9:25 a.	
4. SOCIAL SECURITY NUMBER 162-36-8564		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 86 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7. DATE OF BIRTH (Month, Day, Year) December 5, 1909				8. BIRTHPLACE (State or Foreign Country) Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number) 19015 Three Notch Road				9b. CITY, TOWN OR LOCATION OF DEATH Lexington Park		9c. COUNTY OF DEATH St. Mary's	
RESIDENCE OF DECEDENT							
10a. STATE Pennsylvania		10b. COUNTY CUMBERLAND		10c. CITY, TOWN OR LOCATION Lexington Park		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 200 S. STONER AVENUE				10f. ZIP CODE 17091		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify white							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker		16b. KIND OF BUSINESS/INDUSTRY n/a	
17. FATHER'S NAME (First, Middle, Last) William F. Davis				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret O. Hannon			
19a. INFORMANT'S NAME (Type/Print) John McMahon				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19015 Three Notch Road, Lexington Park, Maryland 20653			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) Holy Cross Cemetery		DATE July 26, 1996		20c. LOCATION — City or Town, State Harrisburg, PA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael K. Blankenship</i> Michael K. Blankenship, M00857				22. NAME AND ADDRESS OF FACILITY Brinsfield Funeral Home, P.A. 59 N. Washington St., Leonardtown, MD 20650-0279			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinomatosis							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
a. DUE TO (OR AS A CONSEQUENCE OF): Cardiomyopathy							
b. DUE TO (OR AS A CONSEQUENCE OF): Diabetes							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO N.A.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29c. SIGNATURE AND TITLE OF CERTIFIER <i>J. Patrick Jarboe</i> J. Patrick Jarboe, M.D., Medical Arts Building, Leonardtown, Maryland 20650				29d. LICENSE NUMBER D06419		29e. DATE SIGNED (Month, Day, Year) July 22, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Patrick Jarboe, M.D., Medical Arts Building, Leonardtown, Maryland 20650							
31. DATE FILED (Month, Day, Year) JUL 23 1996				32. REGISTRAR'S SIGNATURE <i>John A. Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 23296

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Joyce Elizabeth Miller				2. DATE OF DEATH MONTH DAY YEAR July 19, 1996		3. TIME OF DEATH 10:35 p.	
4. SOCIAL SECURITY NUMBER 018-32-0781		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) 54 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 13, 1941	
8. BIRTHPLACE (State or Foreign Country) Massachusetts				9a. FACILITY NAME (If not institution, give street and number) Naval Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Patuxent River	
9c. COUNTY OF DEATH St. Mary's				10a. STATE Maryland		10b. COUNTY St. Mary's	
10c. CITY, TOWN OR LOCATION Lexington Park				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER One Cell Drive, P.O. Box 853	
10f. ZIP CODE 20653-0853				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) homemaker				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker		16b. KIND OF BUSINESS/INDUSTRY n/a	
17. FATHER'S NAME (First, Middle, Last) Thadde Ducharme				18. MOTHER'S NAME (First, Middle, Maiden Surname) Charlotte Bean			
19a. INFORMANT'S NAME (Type/Print) Harold G. Miller				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) One Cell Drive, P.O. Box 853, Lexington Park, MD 20653-0853			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Royal Palm Cemetery July 26, 1996, St. Petersburg, FL		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL HOME EMPLOYEE Edward N. Brinsfield, Jr., MCO052				22. NAME AND ADDRESS OF FACILITY Brinsfield Funeral Home, P.A. 59 N. Washington St., Leonardtown, MD 20650-0279			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. COPD DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) —		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER William D. Boyd II, M.D.				29c. LICENSE NUMBER D14285		29d. DATE SIGNED (Month, Day, Year) July 22, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William D. Boyd II, M.D., 17 Jefferson Street, Leonardtown, Maryland 20650							
31. DATE FILED (Month, Day, Year) JUL 23 1996				32. REGISTRAR'S SIGNATURE John A. Anderson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

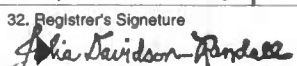
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23297

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SYLVIA METZ				2. Date of Death Month JULY Day 20 , Year 1996		3. Time of Death 10:50 PM	
	4e. Facility Name (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL				4b. City, Town, or Location of Death OLNEY		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 087-12-3434		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F XX		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) APRIL 4, 1908	
	9. Birthplace (State or Foreign Country) NEW YORK		10e. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location BETHESDA	
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10f. Zip Code 20817		10g. Citizen of What Country? UNITED STATES		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced XX		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No XX If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No XX Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME				
17. Father's Name (First, Middle, Last) MAX SCHWARTZ				18. Mother's Name (First, Middle, Maiden Surname) AUGUSTA (UNAVAILABLE)				
19e. Informant's Name/Relationship (Type, Print) DAVID METZ (SON)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6778 SURREYWOOD LANE, BETHESDA, MARYLAND 20817				
20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR PARK CEMETERY		Date 7/22/96		20c. Location - City or Town, State WESTWOOD, NEW JERSEY		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852						
23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. Cerebrovascular Accident Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 18 hours 5 years								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Uremia						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier  M.D.		29c. License number D14057		29d. Date signed (Month, Day, Year) July 20, 1996				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lewis Kellert, M.D. 4000 Olney Laytonsville Rd. Olney, Md. 20832								
31. Date filed (Month, Day, Year) JUL 23 1996		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23298

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LINWOOD ANTHONY MARBURY						2. Date of Death Month Day Year JULY 24, 1996		3. Time of Death 12:29 PM		
	4a. Facility Name (If not institution, give street and number) 5870 MASON SPRINGS ROAD						4b. City, Town, or Location of Death PISGAH		4c. County of Death CHARLES		
Funeral Director	5. Social Security Number 219-12-3888		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) OCT. 23, 1925		9. Birthplace (State or Foreign Country) MARYLAND		
	Usual Residence of Decedent										
10a. State MARYLAND		10b. County CHARLES		10c. City, Town or Location PISGAH				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number #5870 MASON SPRING ROAD				10f. Zip Code 20640		10g. Citizen of What Country? UNITED STATES					
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) 7TH GRADE				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER			16b. Kind of Business/Industry CONSTRUCTION				
17. Father's Name (First, Middle, Last) FRED MARBURY						18. Mother's Name (First, Middle, Maiden Summa) MARY ROBINSON MARBURY					
19a. Informant's Name/Relationship (Type, Print) MABEL LEE / SISTER						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #6715 VERMONT COURT, LANDOVER, MARYLAND 20785					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) SMITH CHAPEL CHURCH CEM.			Data 7/27/96		20c. Location - City or Town, State PISGAH, MARYLAND			
21. Signature of Funeral Service Licensee Lydia C. Thornton Johnson LYDIA C. THORNTON JOHNSON MOC583						22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. #3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrhythmia - probable Due to (or as a consequence of): b. Endstage Renal Failure on dialysis Due to (or as a consequence of): c. Metastatic Carcinoma of prostate Due to (or as a consequence of): d. Chronic obstructive lung disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anaemia, Hypertension										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accidental 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier S. K. Mishra MD		29c. License number D23021		29d. Date signed (Month, Day, Year) 7/25/96					
30. Name and address of person who completed cause of death (from 23a) (Type, Print) S.K. MISHRA, 7-C Postoffice Rd. Waldorf, Md. 20602											
31. Date filed (Month, Day, Year) JUL 26 1996		32. Registrar's Signature John Davidson Randall									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

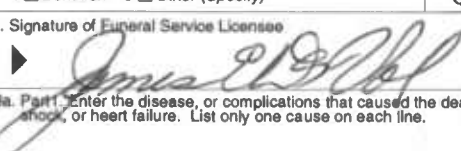
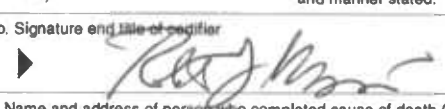
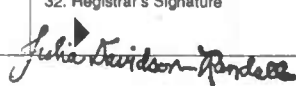
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23299

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) OTIS MACKAY				2. Date of Death Month JULY Day 16 Year 1996		3. Time of Death 2:05 AM		
	4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital				4b. City, Town, or Location of Death Laurel		4c. County of Death Prince George		
Funeral Director	5. Social Security Number 215-18-0479		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 19, 1914	9. Birthplace (State or Foreign Country) Oklahoma	
	Usual Residence of Decedent				10c. City, Town or Location Washington D.C.		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10a. State None		10b. County None		10e. Street and Number 1716 Euclid St., N.W.		10f. Zip Code 20009		
	10g. Citizen of What Country? U.S.A.		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 44-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Boiler Engineer		16b. Kind of Business/Industry Gelman Co.		
	17. Father's Name (First, Middle, Last) Wyatt Mackey				18. Mother's Name (First, Middle, Maiden Summa) Margaret				
	19a. Informant's Name/Relationship (Type, Print) Otis A. Mackey / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11512 Nieman Road Overland Park, Kansas 66210				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Quantico National Cem.		Date 7/19/96		20c. Location - City or Town, State Triangle, Virginia		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin ave., N.W. Washington, D.C. 20007				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): PNEUMONIA Due to (or as a consequence of): UNOS-PSIS Due to (or as a consequence of): DEBILITATION FROM CEREBROVASCULAR ACCIDENT				Approximate Interval Between Onset and Death DAYS DAYS DAYS YEAR				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS HYPERTENSION				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and Title of certifier 		29c. License number D25422		29d. Date signed (Month, Day, Year) JULY 16, 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. Mackey, MD. LAUREL, MD 20708									
31. Date filed (Month, Day, Year) JUL 22 1996		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

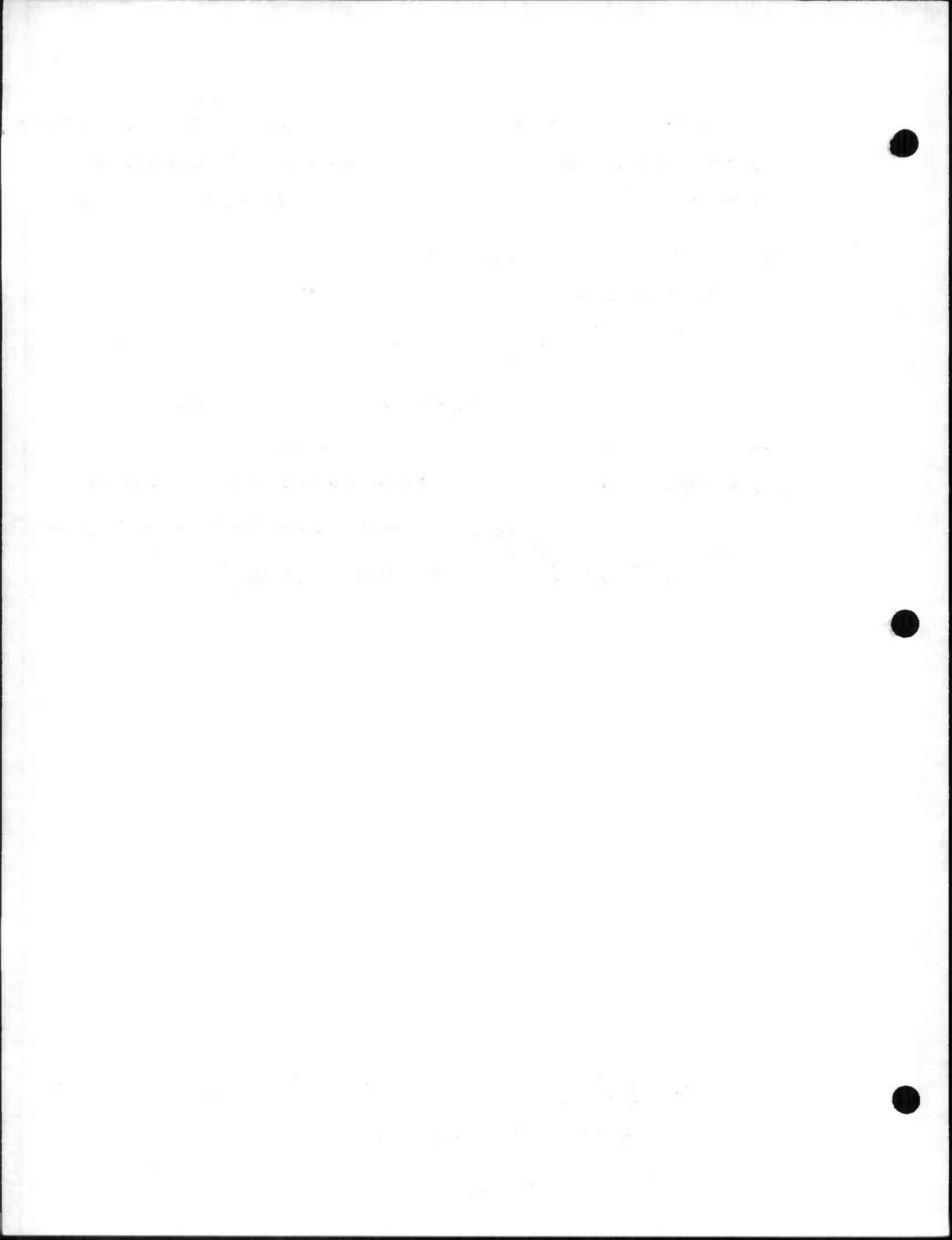
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

3

State
Registrar




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23300

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nettie		2. Date of Death Month July Day 23 Year 1996		3. Time of Death 10:25 PM
	4a. Facility Name (If not institution, give street and number) Randolph Hills Nursing Center		4b. City, Town, or Location of Death Wheaton		4c. County of Death Montgomery
Funeral Director	5. Social Security Number 389-20-5390	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months 0 Days 0	If Under 24 Hrs. Hours 0 Min. 0
	8. Date of Birth (Month, Day, Year) May 20, 1900		9. Birthplace (State or Foreign Country) Wisconsin		
Usual Residence of Decedent					
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 101 Carlisle Drive			10f. Zip Code 20904		10g. Citizen of What Country? United States
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress		16b. Kind of Business/Industry Cafeteria	
17. Father's Name (First, Middle, Last) Christian		18. Mother's Name (First, Middle, Maiden Surname) Never Helena (Unavailable)			
19a. Informant's Name/Relationship (Type, Print) Ron M. Landsman		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #901-N 4550 Montgomery Avenue, Bethesda, MD 20814			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		20c. Location - City or Town, State 7-24 Beltsville, Maryland	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebral Infarct Due to (or as a consequence of): Cerebrovascular Insufficiency Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cerebrovascular Insufficiency Due to (or as a consequence of): Cerebral Infarct					Approximate Interval Between Onset and Death days years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Progressive Dementia; Cachexia					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number D 08944		29d. Date signed (Month, Day, Year) July 24, 1996	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin C. Shargel, M. D., 3720 Farragut Avenue, Kensington, MD 20895					
31. Date filed (Month, Day, Year) JUL 25 1996		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23301

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mahmood Nasrin				2. Date of Death Month July Day 21 Year 1996				3. Time of Death 8:30 am			
	4a. Facility Name (If not institution, give street and number) 15511 Jones Lane				4b. City, Town, or Location of Death North Potomac				4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 213-02-0626		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) May 24, 1918		9. Birthplace (State or Foreign Country) Iran			
	Usual Residence of Decedent				10a. State Maryland		10b. County Montgomery		10c. City, Town or Location North Potomac			
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 15511 Jones Lane				10f. Zip Code 20878			
	10g. Citizen of What Country? Iran				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Collega (1-4 or 5+)			
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Land Developer				16b. Kind of Business/Industry Self Employed				17. Father's Name (First, Middle, Last) Mehdi Nasrin			
	18. Mother's Name (First, Middle, Maiden Surname) Sedijheh Khazeni				19a. Informant's Name/Relationship (Type, Print) Simin N. Kassaei/ Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7234 Wapello Drive Rockville, Maryland 20855			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park				20c. Location - City or Town, State Rockville, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850				23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Progressive Supranuclear Palsy			
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number D37678			
	29d. Date signed (Month, Day, Year) July 22, 1996				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James F. Mackin, M.D. 5401 Western Avenue, NW Washington, D.C. 20015				31. Date filed (Month, Day, Year) JUL 23 1996		32. Registrar's Signature 	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report

2. The second part of the report

3. The third part of the report

4. The fourth part of the report

5. The fifth part of the report

6. The sixth part of the report

7. The seventh part of the report

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10. The tenth part of the report

11. The eleventh part of the report

12. The twelfth part of the report

13. The thirteenth part of the report

14. The fourteenth part of the report

15. The fifteenth part of the report

16. The sixteenth part of the report

17. The seventeenth part of the report

18. The eighteenth part of the report

19. The nineteenth part of the report

20. The twentieth part of the report

21. The twenty-first part of the report

22. The twenty-second part of the report

23. The twenty-third part of the report

24. The twenty-fourth part of the report

25. The twenty-fifth part of the report

26. The twenty-sixth part of the report

27. The twenty-seventh part of the report

28. The twenty-eighth part of the report

29. The twenty-ninth part of the report

30. The thirtieth part of the report

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23302

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PATRICIA J. O'BRIEN		2. Date of Death Month Day Year JULY 22, 1996		3. Time of Death 5:45 PM	
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL		4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death	
Funeral Director	5. Social Security Number 064.22.0767	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	8. Date of Birth (Month, Day, Year) JULY 4, 1927	9. Birthplace (State or Foreign Country) MICHIGAN	
	Usual Residence of Decedent					
To Be Completed by Funeral Director	10a. State MD	10b. County MONTGOMERY	10c. City, Town or Location CHEVY CHASE		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 3800 LELAND STREET		10f. Zip Code 20815		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) +4 Collegia (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		18b. Kind of Business/Industry OWN HOME	
	17. Father's Name (First, Middle, Last) DONALD KINGSLEY		18. Mother's Name (First, Middle, Maiden Surname) CHRISTINA HAUSENTOFFUEL			
	19a. Informant's Name/Relationship (Type, Print) PAUL L. O'BRIEN		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3800 LELAND ST. CHEVY CHASE, MD. 20815			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ARLINGTON NAT. CEMETERY		20c. Location - City or Town, State 7/26/96 ARLINGTON, VIRGINIA	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility JOSEPH GAWLER'S SONS 5130 WI AVE NW WASHINGTON DC 20016			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cancer of the head and neck (metastatic) Due to (or as a consequence of): b. Pneumonia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day Year) 28b. Time of injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier M.D.				
29c. License number N9197		29d. Date signed (Month, Day, Year) July Twenty-second, 1996				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Craig Kinchen, 6816 Bonnie Ridge Drive, Apartment 102, Baltimore, Maryland 21209						
31. Date filed (Month, Day, Year) JUL 25 1996		32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23303

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THOMAS RAYMOND PLUMMER

2. Date of Death

Month Day Year
July 21, 1996

3. Time of Death

0322AM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

505-38-3578

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 29, 1935

9. Birthplace (State or Foreign Country)

Nebraska

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Darnestown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15709 Bondy Lane

10f. Zip Code

20878

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
white15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

District Manager

16b. Kind of Business/Industry

ATT/Communications

17. Father's Name (First, Middle, Last)

Raymond C. Plummer

18. Mother's Name (First, Middle, Maiden Surname)

Mabel L. Wright

19a. Informant's Name/Relationship (Type, Print)

Lonalu H. Plummer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15709 Bondy Lane, Darnestown, MD 20878

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Forest Lawn Cemetery

Date

7/26/96

20c. Location - City or Town, State

Omaha, Nebraska

21. Signature of Funeral Service Licensee

Michael D. Gibbons

22. Name and Address of Facility

DeVol Funeral Home
10 East Deer Park Drive
Gaithersburg, MD 2087723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Septic shock
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

24hrs

b.

Aspiration
Due to (or as a consequence of):

1-2 weeks

c.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Respiratory failure, renal failure,
coronary artery disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. Friedman

29c. License number

24571

29d. Date signed (Month, Day, Year)

July 21, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. Friedman 15225 SHADY GROVE RD, Rockville

31. Date filed (Month, Day, Year)

JUL 24 1996

32. Registrar's Signature

Julia Davidson-Randall

State
RegistrarDeath Certificate cleared by
Medical Examiner J. Mayle

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23304

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bruna Perniola				2. Date of Death Month Day Year July 20, 1996		3. Time of Death 6:48 pm	
	4a. Facility Name (if not institution, give street and number) Allegis of Bethesda				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 019-12-9391		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 100 Yrs.		8. Date of Birth (Month, Day, Year) May 25, 1896	
	9. Birthplace (State or Foreign Country) Italy		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Bethesda	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 6032 Rossmore Drive		10f. Zip Code 20814		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Vito DiGirolamo				18. Mother's Name (First, Middle, Maiden Surname) Vita Maria Porfida			
	19a. Informant's Name/Relationship (Type, Print) Irene Johnson/ Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6032 Rossmore Drive Bethesda, Maryland 20814			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Highland Cemetery		20c. Location - City or Town, State Norwood, Massachusetts		20d. Date July 27, 1996	
	21. Signature of Funeral Service Licensee  M00335				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Sepsis Due to (or as a consequence of): b. Cerebro Vascular Accident Due to (or as a consequence of): c. Coronary Artery Disease Due to (or as a consequence of): d.							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D 23170		29d. Date signed (Month, Day, Year) July 21, 1996		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Gita C. Bakshi M.D. 9406 Old Georgetown Road Bethesda, Maryland 20814-1722								
31. Date filed (Month, Day, Year) JUL 25 1996				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that this death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Amended #1, 7/22/96, MRT, Montgomery County

96 23305

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SARAH E. ADAMS PUGH				2. DATE OF DEATH MONTH DAY YEAR July 18, 1996		3. TIME OF DEATH 2:10 P M			
4. SOCIAL SECURITY NUMBER 217-14-7817		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 24, 1917		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Randolph Hills Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring			9c. COUNTY OF DEATH MONTGOMERY		
RESIDENCE OF DECEDENT				10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10a. STATE MD		10b. COUNTY Montgomery		10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
10e. STREET AND NUMBER 13523 Georgia Ave., #101		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic		15b. KIND OF BUSINESS/INDUSTRY None		16. FATHER'S NAME (First, Middle, Last) Walter Pugh		17. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Hood	
19a. INFORMANT'S NAME (Type/Print) Paul D. Adams (Son)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16713 Brogden Rd., Spencerville, MD 20868		20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ash Memorial Cemetery 7/23		20c. LOCATION — City or Town, State Sandy Spring, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Mawdsue</i>		22. NAME AND ADDRESS OF FACILITY SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Alzheimer's dementia</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):		Approximate interval Between Onset and Death YES			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dehydration, cachexia, renal failure</i>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Martin C. Shalger</i>		29c. LICENSE NUMBER D08944		29d. DATE SIGNED (Month, Day, Year) 7/19/96		29e. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARTIN C SHALGER 3725 FARRAGUT AVE BETHESDA MD 20815	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		31. DATE FILED (Month, Day, Year) JUL 22 1996		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		33. DATE OF DEATH (Month, Day, Year) JUL 18 1996		34. TIME OF DEATH 2:10 P M	

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23306

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES H. POLLARD III

2. Date of Death

JULY

Day

22

Year

1996

3. Time of Death

2:10 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

3757 HOUSTON BRANCH ROAD

4b. City, Town, or Location of Death

FEDERALSBURG

4c. County of Death

CAROLINE

5. Social Security Number

220-68-9731

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

38

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

1/10, 1958

9. Birthplace (State or Foreign Country)

Milford, Del

Usual Residence of Decedent

10a. State

Md.

10b. County

Caroline

10c. City, Town or Location

Federalsburg, Maryland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3757 Houston Branch Road

10f. Zip Code

21632

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Operational Officer

16b. Kind of Business/Industry

Security Co.

17. Father's Name (First, Middle, Last)

James Henry Pollard, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Blanche griffin Pollard

19a. Informant's Name/Relationship (Type, Print)

Wife
Carolann Hartman Pollard19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3757 Houston Branch Rd., Federalsburg, Md. 21632

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Greensboro Cemetery

Date

7/26

20c. Location - City or Town, State

Greensboro, Md.

21. Signature of Funeral Service Licensee

Michael J. Eskow

22. Name and Address of Facility
Federalsburg, Md. 21632
Frampton-Hawkins-Eskow Funeral Home23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. MULTIPLE GUNSHOT WOUNDS

Due to (or as a consequence of):

Sequitally list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☒ Homicide determined28a. Date of Injury
(Month, Day Year)

7 22 96

28b. Time of
Injury

4:00 PM

28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

SHOOTING

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

RESIDENCE

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

3757 HOUSTON BRANCH ROAD, CAROLINE, MD

29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Margarita Korell M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 22, 1996

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 24 1996

32. Registrar's Signature

Julia Davidson-Randall

State

Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23307

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FOZAN QUDSI				2. Date of Death JULY 16, 1996		3. Time of Death 6:00 PM	
	4a. Facility Name (If not institution, give street and number) BLOUDIES DAM PATAPSCO STATE PARK				4b. City, Town, or Location of Death ARBUTUS		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 472-90-8407		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 28 Yrs.		8. Date of Birth (Month, Day, Year) March 4, 1968	
	9. Birthplace (State or Foreign Country) Pakistan		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 5718 Richardson News Sq.		10f. Zip Code 21228		10g. Citizen of What Country? Pakistan	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Asian	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) 4		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Store Manager		16b. Kind of Business/Industry Price Costco Club			
	17. Father's Name (First, Middle, Last) Mahammed Saaid Qudsi				18. Mother's Name (First, Middle, Maiden Surname) Khurshida B. Kazmi			
	19a. Informant's Name/Relationship (Type, Print) Ubaid Qudsi (Brother)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5648 Thunderhill Road Columbia, Maryland 21045			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory, or other place) George Washington Cemetery		20c. Location - City or Town, State Adelphi, Maryland		20d. Date 7/18/1996	
	21. Signature of Funeral Service Licensee <i>Ronald V. Borgwardt</i>				22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Drowning</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) RIVER							
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 7/16/96		28b. Time of Injury 3pm M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred <i>Subject drowned</i>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>State Park</i>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>Patapsco State Park in Baltimore County, Maryland</i>			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier <i>Theodore M. King</i>				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 17, 1996	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>THEODORE M. KING</i> 111 Penn Street, Baltimore, Maryland 21201							
	31. Date filed (Month, Day, Year) JUL 23 1996				32. Registrar's Signature <i>Theodore M. King</i>			

96 23308

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Henry Theodore Robertson, Jr.				2. DATE OF DEATH MONTH DAY YEAR July 23, 1996		3. TIME OF DEATH 4:30 P.M.	
4. SOCIAL SECURITY NUMBER 577-28-4792		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec 17, 1922	
8. BIRTHPLACE (State or Foreign Country) Washington, D.C.				9a. FACILITY NAME (If not institution, give street and number) Archer Street		9b. CITY, TOWN OR LOCATION OF DEATH Compton	
9c. COUNTY OF DEATH St. Mary's				10a. STATE MD		10b. COUNTY St. Marys	
10c. CITY, TOWN OR LOCATION Compton				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER General Delivery	
10f. ZIP CODE 20627				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Service Representative		16b. KIND OF BUSINESS/INDUSTRY Car Dealership	
17. FATHER'S NAME (First, Middle, Last) Henry Theodore Robertson, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Hall			
19a. INFORMANT'S NAME (Type/Print) Lorraine Percell/Daughter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) General Delivery Compton, MD 20627			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery 7/27/96		20c. LOCATION — City or Town, State Suitland, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael L. Gardiner</i>				22. NAME AND ADDRESS OF FACILITY Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
e. <u>LUNG CARCINOMA</u>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. <u>COPD</u>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <u>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</u>							
DUE TO (OR AS A CONSEQUENCE OF):							
d. <u>ATHLETIC FIBRILLATION</u>							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ANXIETY - STRESS SYNDROME</u>							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Th...</i>				29c. LICENSE NUMBER D34539		29d. DATE SIGNED (Month, Day, Year) 7-24-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Khalid M. Husain, M.D. 662 Moakley Street, Leonardtown, MD 20650							
31. DATE FILED (Month, Day, Year) JUL 25 1996				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23309

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Dorothy Ryan

2. Date of Death

Month

Day

Year

July

23

1996

3. Time of Death

12:30 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

577-01-0784

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Aug. 22, 1911

9. Birthplace (State or Foreign Country)

Hyattsville, MD

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Adelphi

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8410 20th Avenue

10f. Zip Code

20783

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

C&P Telephone

17. Father's Name (First, Middle, Last)

Corbin Boorman

18. Mother's Name (First, Middle, Maiden Surname)

Anna Stinefelt

19a. Informant's Name/Relationship (Type, Print)

William F. Ryan

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8410 20th Avenue, Adelphi, MD 20783

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

7/26/96

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins
Funeral Home, Inc. 500 University Blvd. West
Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intracerebral Hemorrhage

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

48 Hours

b. Hypertension

Due to (or as a consequence of):

50 Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Breast Carcinoma

Coronary Artery Disease

Hypothyroidism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D31563

29d. Date signed (Month, Day, Year)

July 24, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles M. Benner, M.D., 11251 Lockwood Drive, Silver Spring, MD 20901

31. Date filed (Month, Day, Year)

JUL 25 1996

32. Registrar's Signature

State
Registrar

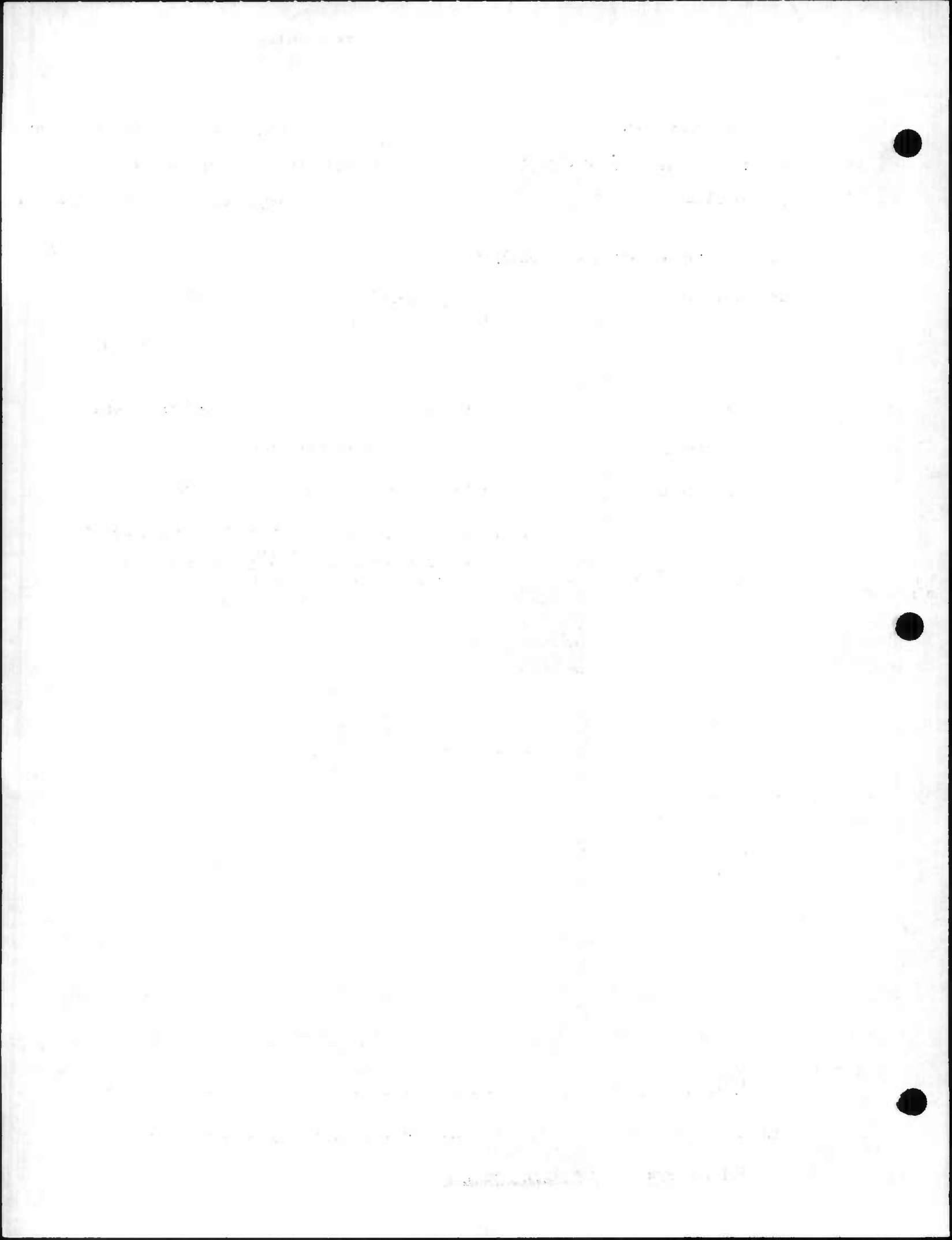
Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 23310**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth Gwendolyn Reed					2. Date of Death Month July Day 23 Year 1996		3. Time of Death 6:25 pm	
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital					4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 360-10-6474		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 10 1915		9. Birthplace (State or Foreign Country) Illinois
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 2108 Seminary Road				10f. Zip Code 20910		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Horace Mann Lewis					18. Mother's Name (First, Middle, Maiden Surname) Anita M. VanHook			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Napoleon J. Reed				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2108 Seminary Road, Silver Spring, MD 20901				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 1 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		Date 7/26/96		20c. Location - City or Town, State Silver Spring, Maryland		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASPIRATION PNEUMONIA Due to (or as a consequence of): b. STROKE w/ DYSPHAGIA S/P GASTROSTOMY TUBE Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate interval Between Onset and Death HOURS YEARS
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ALZHEIMER'S DISEASE								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospice: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D36046		29d. Date signed (Month, Day, Year) 7/23/96			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JOHN J. MERENDINO JR., M.D., 14701 RANDOLPH RD #216 ROCKVILLE, MD 20852									
31. Date filed (Month, Day, Year) JUL 26 1996		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.


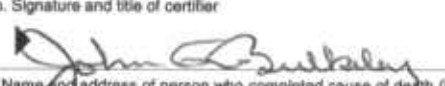
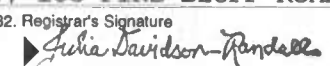
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23311

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ETHEL L RICHARDS				2. Date of Death Month 07 Day 23 Year 96		3. Time of Death 0035	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 215-14-3854		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) 10/24/1910	
	9. Birthplace (State or Foreign Country) Preston, Md.		10a. State Md.		10b. County Caroline		10c. City, Town or Location Denton, Maryland	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 520 Kerr Avenue		10f. Zip Code 21629		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home				
17. Father's Name (First, Middle, Last) Robert Thomas				18. Mother's Name (First, Middle, Maiden Surname) Sadie Marine				
19a. Informant's Name/Relationship (Type, Print) Jeanette Lomax				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 S. Washington St., Easton, MD 21601				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hill Crest Cemetery		Date 7/26		20c. Location - City or Town, State Federalsburg, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Frampton-Hawkins-Eskow Funeral Home Federalsburg, MD 21632				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE RENAL FAILURE Due to (or as a consequence of): b. HYPERKALEMIA Due to (or as a consequence of): c. METABOLIC ACIDOSIS Due to (or as a consequence of): d. SEPSIS								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. POSSIBLE BASILAR SKULL FRACTURE FRACTURE RIGHT SHOULDER ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospitel: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 07-18-96		28b. Time of Injury 0400 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred FELL ON LEVEL SURFACE		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) CAROLINE NURSING HOME		28f. Location (Street and Number or Rural Route Number, City or Town, State) DENTON, MD				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  D.M.E.		29c. License number D03599		29d. Date signed (Month, Day, Year) 07-23-96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY, MD 21801								
31. Date filed (Month, Day, Year) JUL 24 1996		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23312

AMENDED #2, 7/22/96, DLB, ST. MARY'S CO

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GEORGE ALVIN SNOWDEN				2. Date of Death Month 16 Day 17 Year 1996		3. Time of Death 0040 AM	
	4a. Facility Name (If not institution, give street and number) CHARLOTTE HALL VETERANS HOME				4b. City, Town, or Location of Death CHARLOTTE HALL		4c. County of Death ST. MARYS	
Funeral Director	5. Social Security Number 577-28-0572		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) Oct 2, 1912	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Bushwood	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 5 Longview Beach		10f. Zip Code 20618		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-1944		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) 12th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Warehouse Manager		16b. Kind of Business/Industry Furniture Company		17. Father's Name (First, Middle, Last) Charles Snowden	
	18. Mother's Name (First, Middle, Maiden Surname) Carrie Campbell		19a. Informant's Name/Relationship (Type, Print) Mary Evelyn Snowden - Spouse		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Longview Beach, Bushwood, MD 20618		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery		20c. Location - City or Town, State Cheltenham, MD		21. Signature of Funeral Service Licensee <i>Michael K. Gardiner</i>		22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic cardiovascular disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Piece of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
	28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
State Registrar	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 18, 1996	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201		31. Date filed (Month, Day, Year) JUL 22 1996		32. Registrar's Signature <i>John Davidson-Randall</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

96 23313

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mahlon Finley Saunders				2. DATE OF DEATH MONTH DAY YEAR July 21, 1996		3. TIME OF DEATH 11:20 A M	
4. SOCIAL SECURITY NUMBER 577-09-7119		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan 22, 1913 VA	
9a. FACILITY NAME (If not institution, give street and number) Bayside Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Lexington Park		9c. COUNTY OF DEATH St. Mary's	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Clinton		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6808 Friendship Court				10f. ZIP CODE 22747		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Meat Manager		15b. KIND OF BUSINESS/INDUSTRY Retail Food Store			
17. FATHER'S NAME (First, Middle, Last) Mahlon Saunders				18. MOTHER'S NAME (First, Middle, Maiden Surname) Augusta English			
19a. INFORMANT'S NAME (Type/Print) Donald E. Saunders/Son				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9675 Poindexter Ct. Burke, VA 22015			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Trinity Memorial Garden 7/24/96		20c. LOCATION — City or Town, State Waldorf, MD		22. NAME AND ADDRESS OF FACILITY Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael K. Gardiner</i>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Acute Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes Mellitus</i> <i>Peripheral Vascular Disease</i> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James C. Boyd, M.D.</i>				29c. LICENSE NUMBER D149917		29d. DATE SIGNED (Month, Day, Year) 7-22-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James C. Boyd, M.D. California, Maryland 20619							
31. DATE FILED (Month, Day, Year) JUL 23 1996 <i>John Davidson Ruffell</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23314

Amended #6, #18, 7/30/96, MRT, Montg ~~Certificate of Death~~

Reg. No.

Physician
/Medical
Examiner

1. Decedant's Name (First, Middle, Last)

K. C. Parker Solomon

2. Date of Death

Month Day Year
July 19 1996

3. Time of Death

12:46 AM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

None

6. Sex

~~Male~~ ☒ F

7. Age (in yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

15

8. Date of Birth

(Month, Day, Year)
July 19, 1996

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedant

10a. State

10b. County

10c. City, Town or Location

Washington, D. C.

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3803 Jay St. N.E.

10f. Zip Code

20019

10g. Citizen of What Country?

USA

11. Marital Status

☒ Navar Married ☐ Married☐ Widowed ☐ Divorced

12. Was Decedant Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedant's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

None

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Howard Solomon

16. Mother's Name (First, Middle, Maiden Surname)

~~Keturah Nolan~~ Keturah Nolan

19a. Informant's Name/Relationship (Type, Print)

Howard Solomon - Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3803 Jay St. N.E. Washington, D.C. 20019

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Comfort Crematory

Date

7/24/96

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Joseph Gawler's Sons

5130 Wisc. Ave. NW Washington, D.C. 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Preivable Neonate

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

1 hour

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

26a. Date of Injury (Month, Day, Year)

26b. Time of Injury

26c. Injury at Work?

☐ Yes ☒ No

26d. Describe how Injury occurred

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 46711

29d. Date signed (Month, Day, Year)

07/19/96

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Sharon C. Kiernan, MD

1500 Forest Glen Road Silver Spring, MD 20910

31. Date filed (Month, Day, Year)

JUL 25 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

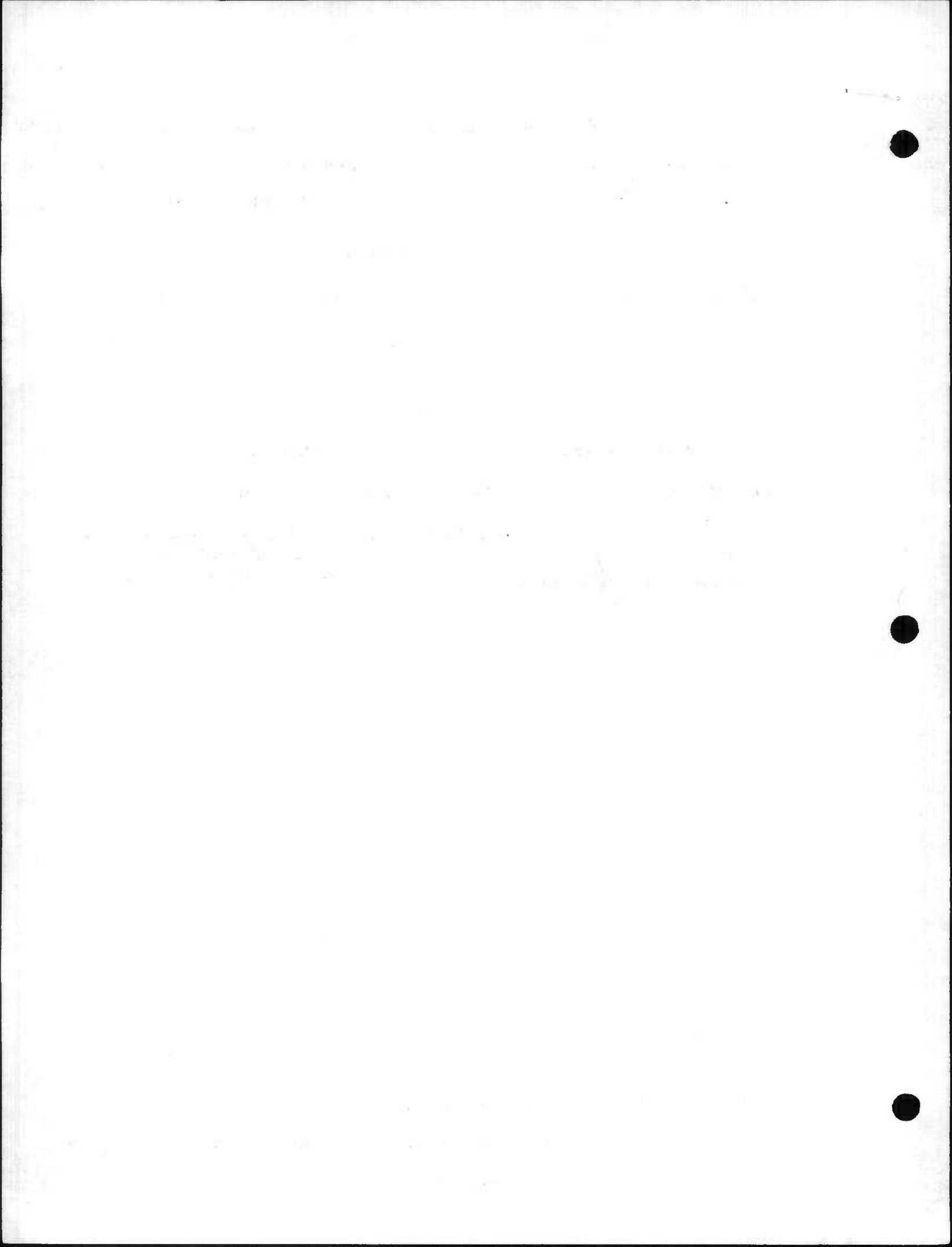
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23315

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elva M. Sanford				2. Date of Death Month July Day 18 Year 1996				3. Time of Death 2:30P.	
	4a. Facility Name (If not institution, give street and number) Manor Care Nursing & Rehabilitation Center				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 577-09-4637		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth Month Jan. Day 25 Year 1907		9. Birthplace (State or Foreign Country) Virginia		Usual Residence of Decedent		10a. State Maryland		10b. County Prince George's	
To Be Completed by Funeral Director	10c. City, Town or Location Hyattsville		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 3900 Hamilton Street, Apt.E102		10f. Zip Code 20781		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)	
	15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Management		16b. Kind of Business/Industry Department Store		17. Father's Name (First, Middle, Last) Abith Pettit		18. Mother's Name (First, Middle, Maiden Surname) Bessie Pettit		19. Informant's Name/Relationship (Type, Print) Judith Diedrich (niece)	
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11608 34th Place Beltsville, Maryland 20705		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) George Washington Cemetery		Date 7/21/1996		20c. Location - City or Town, State Adelphi, Maryland	
	21. Signature of Funeral Service Licensee Donald V. Borgwardt		22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Coronary Artery Disease Due to (or as a consequence of):		Approximate Interval Between Onset and Death 5 years		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulmonary Disease		24a. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier John Margolis, M.D.		29c. License number D35430	
	29d. Date signed (Month, Day, Year) July 19, 1996		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) John Margolis, M.D. 14333 Laurel Bowie Road, #307 Laurel, Maryland 20708		31. Date filed (Month, Day, Year) JUL 23 1996		32. Registrar's Signature John Davidson-Randall			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23316

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY L. STROBERT				2. Date of Death Month Day Year JULY 21, 1996		3. Time of Death 10:15 PM	
	4a. Facility Name (If not institution, give street and number) MAGNOLIA GARDENS NURSING HOME				4b. City, Town, or Location of Death LANHAM		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 256-26-2746		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) JAN. 26, 1918	
	9. Birthplace (State or Foreign Country) GEORGIA		10. Usual Residence of Decedent 10a. State MD. 10b. County PRINCE GEORGES 10c. City, Town or Location GLENN DALE 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		11. Merit Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Funeral Director	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSE	
	17. Fether's Name (First, Middle, Last) LESLIE GREEN HUBBARD		18. Mother's Name (First, Middle, Maiden Surname) MOLLIE FAIRCLOTH		19. Informant's Name/Relationship (Type, Print) FRAN L. WAKEFIELD		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ITEM #10	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHAMBERS CREMATORY		20c. Location - City or Town, State RIVERDALE, MD.		21. Signature of Funeral Service Licensee W.W. Chambers	
	22. Name and Address of Facility MOO091 W. W. CHAMBERS CO., RIVERDALE, MD. 20737		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. CARDIAC ARREST Due to (or as a consequence of): b. HYPERTENSIVE MYOCARDIAL INFARCTION Due to (or as a consequence of): c. CORONARY ARTERY DISEASE Due to (or as a consequence of): d. {		Approximate Interval Between Onset and Death 30 min 1 hrs		23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	29b. Signature and title of certifier John C. Carr MD		29c. License number D16197		29d. Date signed (Month, Day, Year) 7-22-96		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDRES C. HERRERA 9321 WILSON - GARDEN RD LANHAM, MD 20706	
	31. Date filed (Month, Day, Year) JUL 23 1996		32. Registrar's Signature Lisa Davidson-Pendell					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD

Multiple cerebral infarct

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23317

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALICE ANNE SKILLEN				2. Date of Death JULY 21, 1996 Year		3. Time of Death 10:35 AM		
	4a. Facility Name (If not institution, give street and number) MEDIPLEX OF MONTGOMERY VILLAGE				4b. City, Town, or Location of Death MONTGOMERY VILLAGE		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 213-44-9578	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT. 13, 1905		9. Birthplace (State or Foreign Country) PENNSYLVANIA	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County MONTGOMERY		10c. City, Town or Location LAYTONSVILLE			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 23513 POCAHONTAS DRIVE,				10f. Zip Code 20882		10g. Citizen of What Country? UNITED STATES		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ADMINISTRATIVE ASSISTANT		16b. Kind of Business/Industry GOVERNMENT				
	17. Father's Name (First, Middle, Last) TOM HYLAND				18. Mother's Name (First, Middle, Maiden Surname) CHARLOTTE BAKER				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) THOMAS V. WHEAT, NEPHEW				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23513 POCAHONTAS DRIVE, LAYTONSVILLE, MD. 20882				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE NATIONAL CEMETERY		Date 7/25		20c. Location - City or Town, State BALTIMORE, MARYLAND		
	21. Signature of Funeral Service Licensee Muriel H. Barber				22. Name and Address of Facility MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MARYLAND 20882				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Respiratory Failure</u> Due to (or as a consequence of): b. <u>Hypoxemia</u> Due to (or as a consequence of): c. <u>Dementia</u> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death minutes minutes years	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier S. Abulfarag, MD		29c. License number 31391 D		29d. Date signed (Month, Day, Year) JULY 22, 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. SUHAIR ABULFARAG, 481 N. FREDERICK AVENUE, GAITHERSBURG, MARYLAND 20877									
31. Date filed (Month, Day, Year) JUL 23 1996		32. Registrar's Signature John Davidson-Hendell							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23318

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Chameli Sharma				2. Date of Death Month Day Year July 22, 1996		3. Time of Death 10:44 PM	
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 144-84-8770	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 15, 1925		9. Birthplace (State or Foreign Country) India
	Usual Residence of Decedent							
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Gaithersburg			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 18758 Cross Country Lane				10f. Zip Code 20879		10g. Citizen of What Country? India		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Indian		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Ram J. Sharma				18. Mother's Name (First, Middle, Maiden Surname) Ramkali Sharma				
19a. Informant's Name/Relationship (Type, Print) Pramod K. Sharma				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date 7-23-96		20c. Location - City or Town, State Beltsville, Maryland		
21. Signature of Funeral Service Licensee Deleen H. Rapp				22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Cause (Final disease or condition resulting in death) a. Cerebral Hemorrhage Due to (or as a consequence of): b. Respiratory Failure - Adult Respiratory Distress Syndrome Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 11 Days 7 Days
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. STATUS POST CRANIOTOMY HYPERTENSION						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier John A. Smith MD		29c. License number D18726		29d. Date signed (Month, Day, Year) July 23, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARTHUR SCHOENBOLD, MD. 1811 Prince Philip Drive, OLNEY Maryland								
31. Date filed (Month, Day, Year) JUL 24 1996		32. Registrar's Signature Jill Davidson-Randall						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23319

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANK A. SANTILHANO		2. Date of Death Month JULY Day 21 Year 1996		3. Time of Death 10:20 AM
	4a. Facility Name (If not institution, give street and number) 9 ROSANNE LANE		4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY
Funeral Director	5. Social Security Number 219-74-0718	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 38 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) May 17, 1958		9. Birthplace (State or Foreign Country) Washington, D.C.		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Rockville		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 9 Roseanne Lane		10f. Zip Code 20850		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baker		16b. Kind of Business/Industry Bakery		
	17. Father's Name (First, Middle, Last) Abraham Santilhano		18. Mother's Name (First, Middle, Maiden Surname) Rosalee Knoop		
	19a. Informant's Name/Relationship (Type, Print) Rosalie Santilhano / Mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13507 Grenoble Drive, Rockville, Maryland 20853		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park		20c. Location - City or Town, State Rockville, Maryland
	21. Signature of Funeral Service Licensee Alan J. Donnell		22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904		
Physician /Medical Examiner	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. RUPTURE OF MYOCARDIAL INFARCT Due to (or as a consequence of): b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
State Registrar	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Harold P. Kono		29c. License number O.C.M.E.
	29d. Date signed (Month, Day, Year) JULY 22, 1996		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) HAROLD P. KONO 111 Penn Street, Baltimore, Maryland 21201		
	31. Date filed (Month, Day, Year) JUL 24 1996		32. Registrar's Signature John L. ...		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23320

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Kartar Singh

2. Date of Death
Month Day Year

July 25 1996

3. Time of Death

8:38 AM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

220-35-8132

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

8. Date of Birth (Month, Day, Year)

Apr 15, 1924

9. Birthplace (State or Foreign Country)

India/Pakistan

Usual Residence of Decedent

10a. State

Md

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

14200 Wolf Creek Place Apt#1

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 Yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Personnel Executive

16b. Kind of Business/Industry

S.T.C.

17. Father's Name (First, Middle, Last)

Jivan Singh

18. Mother's Name (First, Middle, Maiden Surname)

Bhagwanti Kour

19a. Informant's Name/Relationship (Type, Print)

Bhajjan Kour (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14200 Wolf Creek Pl, Silver Spring, Md 20906

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 7/26 Alexandria, Va

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

George R. Snowden

22. Name and Address of Facility

Snowden Funeral Home P.A. 20850 Rockville, Md

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC COLON CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. CHRONIC OBSTRUCTION

Due to (or as a consequence of):

c. MALNUTRITION

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George R. Snowden

29c. License number

D27427-AD

29d. Date signed (Month, Day, Year)

7-25-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATAY BAKSKI, 9406 OLD GEORGETOWN RD, BETHESDA, MD 20814

31. Date filed (Month, Day, Year)

JUL 26 1996

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23321

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lauretta H. Swearingen				2. Date of Death Month July Day 22 Year 1996				3. Time of Death 1:40 p.m.						
	4a. Facility Name (If not institution, give street and number) Springhouse-Westwood Nursing Center				4b. City, Town, or Location of Death Bethesda				4c. County of Death Montgomery						
Funeral Director	5. Social Security Number 579.09.5752		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) Nov. 1, 1904		9. Birthplace (State or Foreign Country) Indiana		
	Usual Residence of Decedent														
10a. State		10b. County		10c. City, Town or Location Washington D.C.						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 3317 Tennyson Street, N.W.						10f. Zip Code 20015				10g. Citizen of What Country? U.S.A.					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White						
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College						18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Manager				16b. Kind of Business/Industry Keystone Kitchen Cabinets					
17. Father's Name (First, Middle, Last) Rueben Harrison						18. Mother's Name (First, Middle, Maiden Surname) Catherine McMahon									
19e. Informant's Name/Relationship (Type, Print) Joan S. Robinson						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39 Highland Avenue Rumson, N.J. 07760									
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington Nat. Cem.				Date 7/31/96		20c. Location - City or Town, State Arlington, Virginia					
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Joseph Gawler's Sons 5130 WI AVE NW WASHINGTON DC 20016									
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
Immediate Cause (Final disease or condition resulting in death) Sepsis												Hours			
Due to (or as a consequence of):															
Due to (or as a consequence of):															
Due to (or as a consequence of):															
Due to (or as a consequence of):															
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimers Disease												23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
												24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. Signature and title of certifier 						29c. License number D354520		29d. Date signed (Month, Day, Year) 7/27/96							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lila McConnell, M.D. 5530 Wisconsin Ave. Chevy Chase, Md. 20816															
31. Date filed (Month, Day, Year) JUL 25 1996						32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23322

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CYNTHIA E. SUBLETT				2. Date of Death Month Day Year JULY 19, 1996		3. Time of Death 8:52 PM	
	4a. Facility Name (If not institution, give street and number) FT. WASHINGTON HOSPITAL				4b. City, Town, or Location of Death FT. WASHINGTON		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 093-43-4949	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 44 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAR. 13, 1952	9. Birthplace (State or Foreign Country) NEW YORK	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD.	10b. County PRINCE GEORGES	10c. City, Town or Location FT. WASHINGTON			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 1700 THOMAS RD.			10f. Zip Code 20744		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COUNSELOR		16b. Kind of Business/Industry MY SISTERS PLACE		
	17. Father's Name (First, Middle, Last) WILLIAM SUBLETT SR.				18. Mother's Name (First, Middle, Maiden Surname) LURAY D. MURRAY			
	19a. Informant's Name/Relationship (Type, Print) JEENECA CANNON			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ITEM #10				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SILVER MOUNT CEMETERY		Data 7/24		20c. Location - City or Town, State STATEN ISLAND, N.Y.	
	21. Signature of Funeral Service Licensee W.W. Chambers			22. Name and Address of Facility W. W. CHAMBERS CO., RIVERDALE, MD. 20737				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACQUIRED IMMUNE DEFICIENCY SYNDROME 1 1/2 YEARS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier W. W. Chambers				29c. License number D 14646		29d. Date signed (Month, Day, Year) 7-20-96		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARTIN S ROSENTHAL MD 10810 CONNECTICUT AVE. KEESVILLE MD 20895								
31. Date filed (Month, Day, Year) JUL 22 1996				32. Registrar's Signature John Davidson-Randall				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

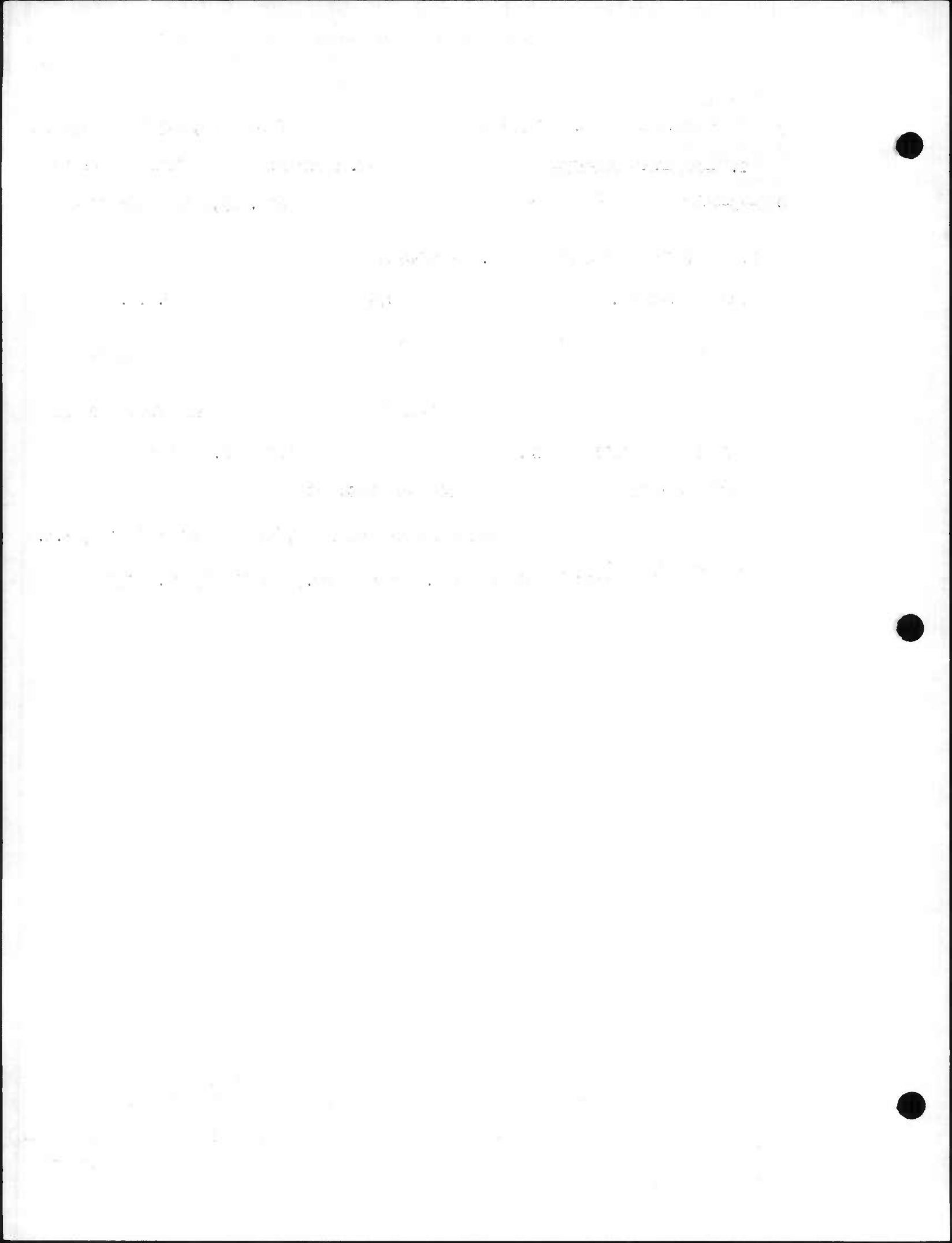
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23323

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELIZABETH L SCHELLER				2. Date of Death Month 7 Day 25 Year 96		3. Time of Death 12:45 PM	
	4a. Facility Name (If not institution, give street and number) CARROLL COUNTY HOSPITAL				4b. City, Town, or Location of Death WESTMINSTER		4c. County of Death CARROLL	
Funeral Director	5. Social Security Number 196-16-1191		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) July 26, 1925	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State MD		10b. County Carroll		10c. City, Town or Location Westminster	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 520 Treemont Drive, Unit #11		10f. Zip Code 21157		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LPN		16b. Kind of Business/Industry nursing home			
	17. Father's Name (First, Middle, Last) Fenton Apgar				18. Mother's Name (First, Middle, Maiden Surname) Jeannie Pollock			
	19a. Informant's Name/Relationship (Type, Print) Ernest G. Scheller Jr., son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4935 Jalmia Road, Mt. Airy, MD 21771			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremations		20c. Location - City or Town, State Hampstead, MD		20d. Date 7/27/96	
	21. Signature of Funeral Service Licensee Katharine Pites - Switzer				22. Name and Address of Facility Pitts Funeral Home & Chapel 412 Washington Rd., Westminster, MD 21157			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction Day 1 Due to (or as a consequence of): Diabetes Mellitus Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier MD		29c. License number D33475		29d. Date signed (Month, Day, Year) 7-25-96				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6965 N. CHARLES ST Baltimore MD 21104								
31. Date filed (Month, Day, Year) JUL 29 1996		32. Registrar's Signature John Andrew Randall						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23324

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>MINZHONG TANG</i>		2. Date of Death Month <i>JULY</i> Day <i>20</i> Year <i>1996</i>		3. Time of Death <i>8.05 PM</i>
	4a. Facility Name (If not institution, give street and number) <i>SHADY GROVE ADVENTIST HOSPITAL</i>		4b. City, Town, or Location of Death <i>ROCKVILLE</i>		4c. County of Death <i>MONTGOMERY</i>
Funeral Director	5. Social Security Number <i>None</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>67</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <i>Jan. 15, 1929</i>		9. Birthplace (State or Foreign Country) <i>China</i>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10c. City, Town or Location		
	10a. State <i>Anhui, China</i>	10b. County <i>none</i>	10c. City, Town or Location <i>Hefei</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <i>Hefei Poly-Technical Building 28, #306</i>		10f. Zip Code <i>none</i>		10g. Citizen of What Country? <i>China</i>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <i>Asian</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4</i> College (1-4 or 5+) <i>4</i>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Professor</i>		16b. Kind of Business/Industry <i>University</i>		
	17. Father's Name (First, Middle, Last) <i>Wenxiao Tang</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Si Zhu</i>		
	19a. Informant's Name/Relationship (Type, Print) <i>Tracy Tang/daughter</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>12106 Stardrift Drive, Germantown, MD 20876</i>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Montgomery Crematorium, Inc.</i>		20c. Location - City or Town, State <i>Bethesda, Maryland</i>
	21. Signature of Funeral Service Licensee <i>Randy Tang</i> M00198		22. Name and Address of Facility <i>Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805</i>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or renal failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) <i>Cardio pulmonary failure</i>				<i>4 days</i>
	Due to (or as a consequence of):				
	<i>Pancreatitis</i>				<i>7 days</i>
	Due to (or as a consequence of):				
	<i>Multi-organ failure</i>				<i>6 days</i>
	Due to (or as a consequence of):				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury <i>M</i>	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Maruth S. Manney MD</i>		29c. License number <i>D44777</i>		29d. Date signed (Month, Day, Year) <i>JULY, 21, 1995</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>MARUTH S. MANNEY - 2041 ROXBURG BLVD, ROCKVILLE, M.D.</i>					
31. Date filed (Month, Day, Year) <i>JUL 23 1996</i>		32. Registrar's Signature <i>Julia Davidson-Randall</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23325

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Mary B. Turner				2. Date of Death Month July Day 16 Year 1996		3. Time of Death 9:04 A.	
4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL				4b. City, Town, or Location of Death FREDERICK		4c. County of Death FREDERICK	
5. Social Security Number 579-44-3781		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 29, 1907	
9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Carroll		10c. City, Town or Location Mt. Airy	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 720 W. Watersville Road		10f. Zip Code 21771		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th		15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Home		17. Father's Name (First, Middle, Last) Edward Campbell	
18. Mother's Name (First, Middle, Maiden Surname) Sadie Foreman		19a. Informant's Name/Relationship (Type, Print) Minnie Tyler (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 720 Watersville Road, Mt. Airy, MD 21771		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) St. Marks Cemetery		20c. Date 7/22/96		20d. Location - City or Town, State Boys, MD		21. Signature of Funeral Service Licensee George K. Brown	
22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Cholecystitis Due to (or as a consequence of): Cholelithiasis Due to (or as a consequence of): Chronic liver disease		Approximate Interval Between Onset and Death 24 hours days unknown unknown		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
29b. Signature and title of certifier Carolyn Baier MD		29c. License number D34386		29d. Date signed (Month, Day, Year) 7/18/96		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Carolyn Baier MD 1 No. Main St., Mt. Airy, MD 21771	
31. Date filed (Month, Day, Year) JUL 22 1996		32. Registrar's Signature J. Davidson-Randall		33. State Registrar		34. State Registrar	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23326

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Francis Leonard Thomas				2. Date of Death Month July Day 19 Year 1996		3. Time of Death 8:10 a.m.	
	4a. Facility Name (If not institution, give street and number) 9226 Gross Avenue				4b. City, Town, or Location of Death Laurel		4c. County of Death HOWARD	
Funeral Director	5. Social Security Number 212-20-1803		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 8, 1924	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State MD		10b. County Howard		10c. City, Town or Location Laurel			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 9226 Gross Avenue				10f. Zip Code 20723		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Water & Sewage Maint.			16b. Kind of Business/Industry U.S.D.A.	
17. Father's Name (First, Middle, Last) Richard Thomas				18. Mother's Name (First, Middle, Maiden Surname) Maggie Matthews				
19a. Informant's Name/Relationship (Type, Print) Estelle L. Thomas (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9226 Gross Avenue, Laurel, MD 20723				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Md. Veterans Cem.		Date 7/24		20c. Location - City or Town, State Crownsville, MD		
21. Signature of Funeral Service Licensee <i>George K. Thomas</i>				22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aspiration Pneumonia Due to (or as a consequence of): b. Adenocarcinoma of lung stage IV Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 4 months.
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic anemia, bone pain Anorexia - Cachexia								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Jon K. Mumferson</i>		29c. License number D30573		29d. Date signed (Month, Day, Year) 7-23-96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 Knoll North Columbia MD 21045								
31. Date filed (Month, Day, Year) JUL 24 1996		32. Registrar's Signature <i>Julia Davidson-Randall</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

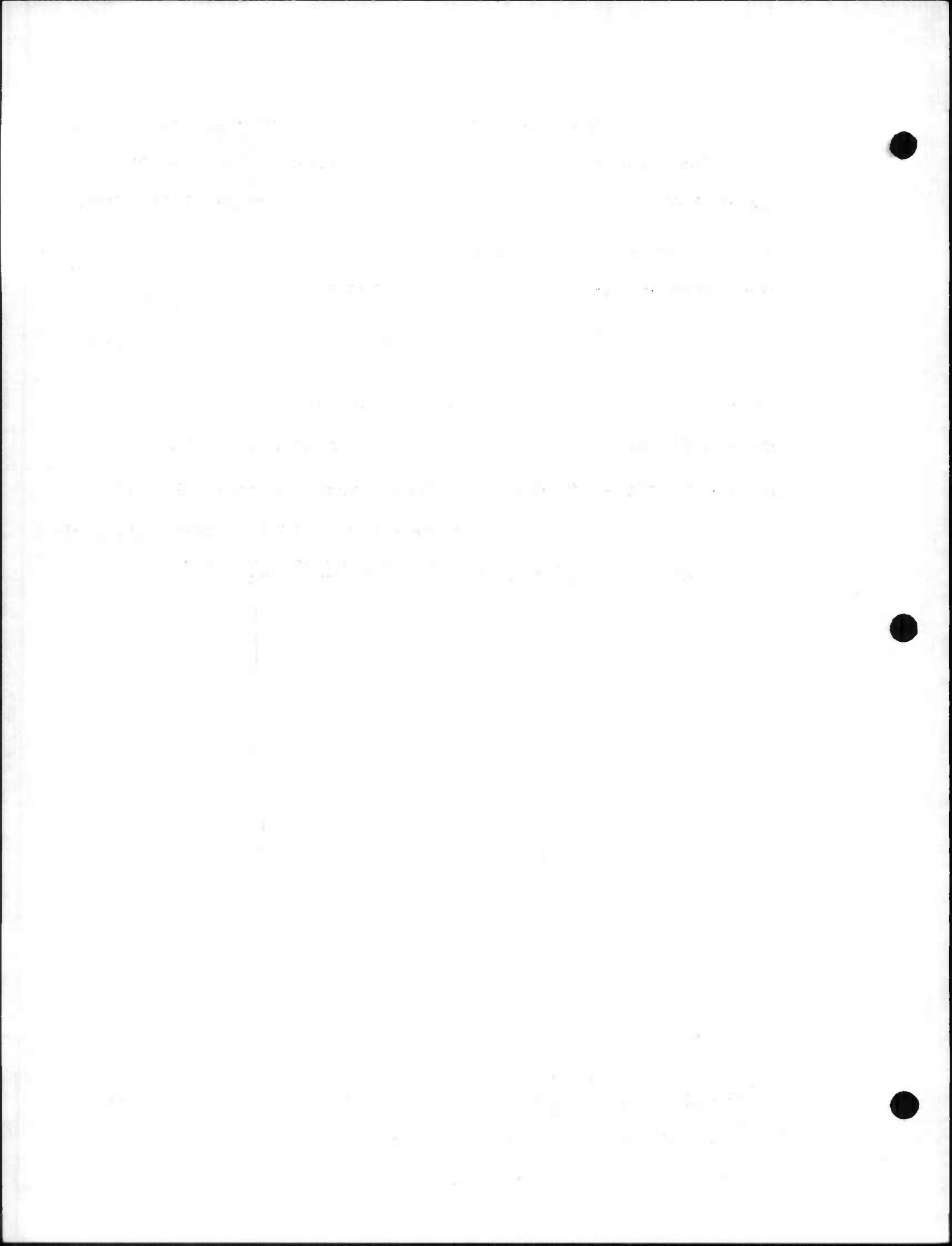
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



96 23327

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Ronald Lee Thompson</u>				2. DATE OF DEATH MONTH <u>July</u> DAY <u>21</u> YEAR <u>1996</u>		3. TIME OF DEATH <u>1550</u> M		
4. SOCIAL SECURITY NUMBER <u>234-32-1196</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>71</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>NOV. 27, 1924</u>		
9a. FACILITY NAME (If not institution, give street and number) <u>SHADY GROVE ADVENTIST HOSPITAL</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>ROCKVILLE</u>		9c. COUNTY OF DEATH <u>MONTGOMERY</u>		
10a. STATE <u>MD.</u>		10b. COUNTY <u>MONTGOMERY</u>		10c. CITY, TOWN OR LOCATION <u>ROCKVILLE</u>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER <u>500 LINCOLN ST.</u>				10f. ZIP CODE <u>20850</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>WWII</u>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>WHITE</u>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 8+) <u></u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>TILE SETTER</u>		16b. KIND OF BUSINESS/INDUSTRY <u>CONSTRUCTION</u>				
17. FATHER'S NAME (First, Middle, Last) <u>RALPH THOMPSON</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>ETHEL PHILLIPS</u>				
19a. INFORMANT'S NAME (Type/Print) <u>ROBERT L. THOMPSON</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>SAME AS ITEM #10</u>				
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>CHAMBERS CREMATORY</u>		DATE <u>7/24</u>		20c. LOCATION — City or Town, State <u>RIVERDALE, MD.</u>		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>W.W. Chambers</u> M00091				22. NAME AND ADDRESS OF FACILITY <u>W. W. CHAMBERS CO. INC., SILVER SPRING, MD.</u> 20910				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. Respiratory Failure</u> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <u>b. Emphysema</u> <u>c. Respiratory Infection</u> <u>d.</u>							Approximate Interval Between Onset and Death <u>Four Days</u> <u>UNK.</u> <u>UNK.</u>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Renal Failure</u> <u>Heart Failure</u> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED				
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Christy Lyons</u>				29c. LICENSE NUMBER <u>031839</u>		29d. DATE SIGNED (Month, Day, Year) <u>July 22, 1996</u>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Christopher C. Dunford</u> <u>615 West Montgomery Ave Rockville, MD 20850</u>								
31. DATE FILED (Month, Day, Year) <u>JUL 24 1996</u>				32. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

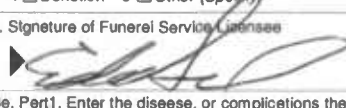
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23328

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Madolyn D. Tabakin				2. Date of Death Month July Day 18 Year 1996		3. Time of Death 7:55 PM	
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 017-18-2597		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 15, 1921	9. Birthplace (State or Foreign Country) Massachusetts
	Usual Residence of Decedent				10c. City, Town or Location silver Spring		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. State MD		10b. County Montgomery		10f. Zip Code 20901		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Communication Specialist		16b. Kind of Business/Industry Communication				
17. Father's Name (First, Middle, Last) Nathan Doress				18. Mother's Name (First, Middle, Maiden Surname) Anna Gedansky				
19a. Informant's Name/Relationship (Type, Print) Ralph Tabakin/Spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10605 Tenbrook Dr, Silver Spring, MD 20901				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Judean Memorial Gardens		Date 7/21		20c. Location - City or Town, State Olney, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852				
23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pancreas Cancer				Approximate Interval Between Onset and Death 1 year				
23b. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.				23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Bruce A. Silver, MD		29c. License number D21463		29d. Date signed (Month, Day, Year) 7-19-96		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Bruce A. Silver, M.D. 2101 Medical Park Dr., Silver Spring, MD 20902								
31. Date filed (Month, Day, Year) JUL 24 1996		32. Registrar's Signature Juba Davidson-Randall						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

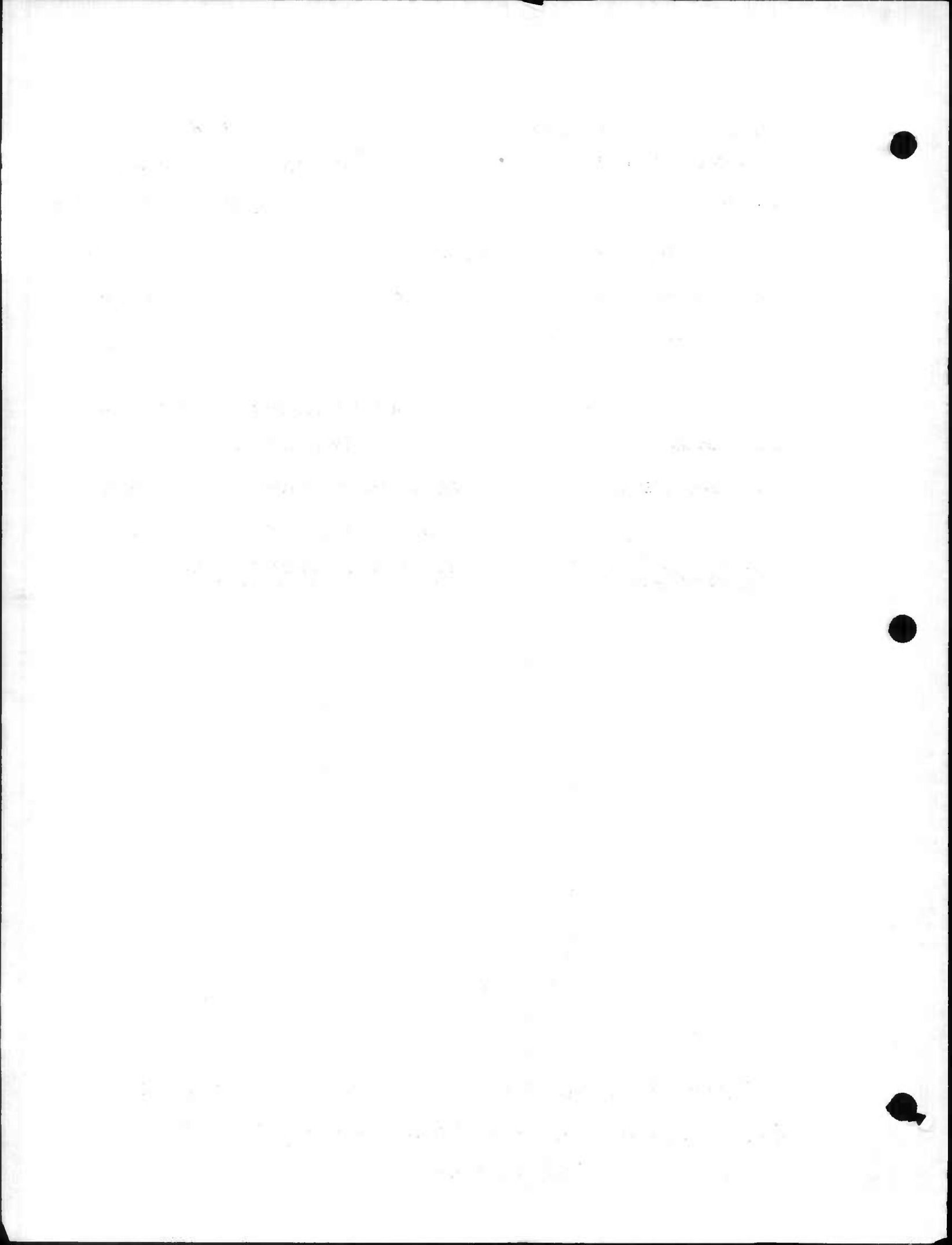
Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23329

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BLANCHE V. THOMPSON				2. Date of Death Month Day Year JULY 24 1996				3. Time of Death 3:30 AM	
	4a. Facility Name (If not Institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				4b. City, Town, or Location of Death TOWSON				4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 213-24-8273		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) Aug 12, 1927		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Upperco				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 212 Mt. Carmel Road				10f. Zip Code 21155		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife				16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) John Herman Seipp				18. Mother's Name (First, Middle, Maiden Surname) Minnie Viola Kelbaugh					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Kenneth Thompson- son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3110 Mt. Carmel Rd, Upperco, MD 21155					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Forest Baptist Cemetery		20c. Date 7-27		20d. Location - City or Town, State Upperco, Md			
	21. Signature of Funeral Service Licensee Steven W. Elise				22. Name and Address of Facility Eline Funeral Home 934 S. Main St, Hampstead, Md 21074					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Septic shock Due to (or as a consequence of): b. Pneumonia Due to (or as a consequence of): c. Pancytopenia Due to (or as a consequence of): d. Felty's Syndrome									
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Rheumatoid arthritis, intracerebral hemorrhage, pneumonia, malnutrition									
State Registrar	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier David G. Roberts (Attending)				29c. License number D34988		29d. Date signed (Month, Day, Year) 7-25-96	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) David G. Roberts, M.D., 10755 Falls Rd., Suite 460, Lutherville, Md. 21093									
	31. Date filed (Month, Day, Year) JUL 29 1996				32. Registrar's Signature John Andrew Randall					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

96 23330

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>MARY</i>				2. DATE OF DEATH MONTH <i>July</i> DAY <i>24</i> YEAR <i>1996</i>				3. TIME OF DEATH <i>3:30 A M</i>	
4. SOCIAL SECURITY NUMBER <i>211.10.0062</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>77</i> YRS.		IF UNDER 1 YEAR MONTHS <i>5</i> DAYS <i>10</i>		IF UNDER 24 HRS. HOURS <i>1</i> MIN. <i>00</i>	
7. DATE OF BIRTH (Month, Day, Year) <i>FEB. 23, 1919</i>				8. BIRTHPLACE (State or Foreign Country) <i>PENNSYLVANIA</i>					
9a. FACILITY NAME (If not institution, give street and number) <i>WASHINGTON ADVENTIST HOSPITAL</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>TAKOMA PARK</i>				9c. COUNTY OF DEATH <i>MONTGOMERY</i>	
10a. STATE <i>PA</i>				10b. COUNTY <i>LUZERNE</i>		10c. CITY, TOWN OR LOCATION <i>SHAVERTOWN</i>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>382 HARRIS HILL ROAD</i>		10f. ZIP CODE <i>18708</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>XX</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <i>XX</i>				14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 6+) <i>XX</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>HOMEMAKER</i>				16b. KIND OF BUSINESS/INDUSTRY <i>OWN HOME</i>	
17. FATHER'S NAME (First, Middle, Last) <i>VINCENT TRETTS</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>LORETTA CAWLEY</i>					
19a. INFORMANT'S NAME (Type/Print) <i>JOSEPH R. VICTOR</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>382 HARRIS HILL RD. SHAVERTOWN, PA 18708</i>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>XX</i>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>ST. IGNATIUS CEMETERY</i>				20c. LOCATION — City or Town, State <i>7/27 PRINGLE, PA</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Deborah M. Peters</i>				22. NAME AND ADDRESS OF FACILITY <i>JOSEPH GAWLER'S SONS</i> <i>5130 WI AVE. N.W. WDC 20016</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Arrhythmia</i>								<i>Minutes</i>	
DUE TO (OR AS A CONSEQUENCE OF):									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Coronary Artery Disease</i>								<i>Years</i>	
DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <i>XX</i>					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Thomas M. Miltano MD</i>				29c. LICENSE NUMBER <i>D36207</i>	
29d. DATE SIGNED (Month, Day, Year) <i>July 24, 1996</i>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>DR. THOMAS MILTANO 7610 CARROLL AVE. TAKOMA PARK MD 20912</i>					
31. DATE FILED (Month, Day, Year) <i>JUL 25 1996</i>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 23331

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RONALD ALLEN WILSON				2. DATE OF DEATH MONTH DAY YEAR July 19, 1996		3. TIME OF DEATH 10:30 p. M	
4. SOCIAL SECURITY NUMBER 222-32-3828		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 38 YRS.		7. DATE OF BIRTH (Month, Day, Year) October 20, 1957	
9a. FACILITY NAME (If not institution, give street and number) 414 Clarks Landing Road				9b. CITY, TOWN OR LOCATION OF DEATH Hollywood		9c. COUNTY OF DEATH St. Mary's	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY St. Mary's		10c. CITY, TOWN OR LOCATION Hollywood		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 414 Clarks Landing Road				10f. ZIP CODE 20636		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1974-1977		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer		16b. KIND OF BUSINESS/INDUSTRY Government			
17. FATHER'S NAME (First, Middle, Last) Robert Cecil Wilson, Jr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Elizabeth Warren			
19a. INFORMANT'S NAME (Type/Print) Robert Cecil Wilson, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 2, Box 351, Seaford, Delaware 19973			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. LOCATION — City or Town, State 7-21-96 Alexandria, Virginia		20d. DATE 7-21-96	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward N. Brinsfield, Jr.</i> Edward N. Brinsfield, Jr., MD0052				22. NAME AND ADDRESS OF FACILITY Brinsfield Funeral Home, P.A. 59 N. Washington St., Leonardtown, MD 20650-0279			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Suicide, gunshot wound to the head DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death seconds
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Depression							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED Gunshot wound to head, suicide		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) home		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) home	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William D. Boyd II</i> William D. Boyd II, M.D., 17 Jefferson Street, Leonardtown, Maryland 20650				29c. LICENSE NUMBER D14285		29d. DATE SIGNED (Month, Day, Year) 7/22/1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William D. Boyd II, M.D., 17 Jefferson Street, Leonardtown, Maryland 20650				31. DATE FILED (Month, Day, Year) JUL 23 1996			
32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23332

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES E. WALKER, SR.				2. Date of Death Month JULY Day 11 Year 1996				3. Time of Death 6:45pm	
	4a. Facility Name (If not institution, give street and number) PRESIDENTIAL WOODS HEALTH CARE CENTER				4b. City, Town, or Location of Death HYATTSVILLE				4c. County of Death PRINCE GEORGE'S	
Funeral Director	5. Social Security Number 229-18-3390		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Dec. 6, 1922		9. Birthplace (State or Foreign Country) Virginia		10a. State Md.		10b. County Prince Georges		10c. City, Town or Location Landover	
Usual Residence of Decedent										
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
10e. Street and Number 1807 Virginia Avenue										
10f. Zip Code 20785										
10g. Citizen of What Country? United States										
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced										
12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:										
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:										
14. Race - American Indian, Black, White, etc. Specify: Black										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+) College (1-4 or 5+)										
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Worker										
16b. Kind of Business/Industry Private Industry										
17. Father's Name (First, Middle, Last) Elice Walker										
18. Mother's Name (First, Middle, Maiden Surname) Parzer Windson										
19a. Informant's Name/Relationship (Type, Print) Jefferson McNair - Friend										
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Rittenhouse St., N.E., Wash., D.C. 20011										
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)										
20b. Place of Disposition (Name of cemetery, crematory or other place) Glenwood Cemetery										
20c. Location - City or Town, State 7/16/96 Washington, D. C.										
21. Signature of Funeral Service Licensee 										
22. Name and Address of Facility R. N. Horton Co. Morticians, Inc. 600 Kennedy Street, N. W., Wash., D.C. 20011										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cancer of Urinary Bladder Due to (or as a consequence of): b. Metastatic disease Due to (or as a consequence of): c. Chronic obstructive lung disease Due to (or as a consequence of): d.										
Approximate Interval Between Onset and Death one year one year years.										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. General weight loss.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined										
28a. Date of Injury (Month, Day Year) N/A										
28b. Time of Injury N/A										
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
28d. Describe how injury occurred N/A										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) N/A										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 										
29c. License number D19609										
29d. Date signed (Month, Day, Year) 7-19-96										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Raman Tuli, 3503 Perry St. Suite B MT. Rainier MD 20712										
31. Date filed (Month, Day, Year) JUL 22 1996										
32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23333

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Lee Winters				2. Date of Death Month July Day 21 Year 1996				3. Time of Death 5:40am	
	4a. Facility Name (If not institution, give street and number) 7365 Oskaloosa Drive				4b. City, Town, or Location of Death Derwood				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 241-40-6805		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Feb. 13, 1931		9. Birthplace (State or Foreign Country) North Carolina		10e. State Maryland		10b. County Montgomery		10c. City, Town or Location Derwood	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10f. Street and Number 7365 Oskaloosa Drive		10g. Zip Code 20855		10h. Citizen of What Country? United States		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1950 to 1951		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Lawyer	
	16b. Kind of Business/Industry Federal Government		17. Father's Name (First, Middle, Last) Morrison M. Winters, Sr.		18. Mother's Name (First, Middle, Maiden Surname) Evelyn May Galvin		19a. Informant's Name/Relationship (Type, Print) Norma Lee Winters		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7365 Oskaloosa Drive, Derwood, MD 20855	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park		Date 7/23/96		20c. Location - City or Town, State Rockville, MD		21. Signature of Funeral Service Licensee 	
	22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Colon Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death 2years, 3mo.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
	28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D 43043		29d. Date signed (Month, Day, Year) July 22, 1996		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George A. Sotos, MD 9707 Medical Center Drive, #300, Rockville, MD 20850	
	31. Date filed (Month, Day, Year) JUL 24 1996		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

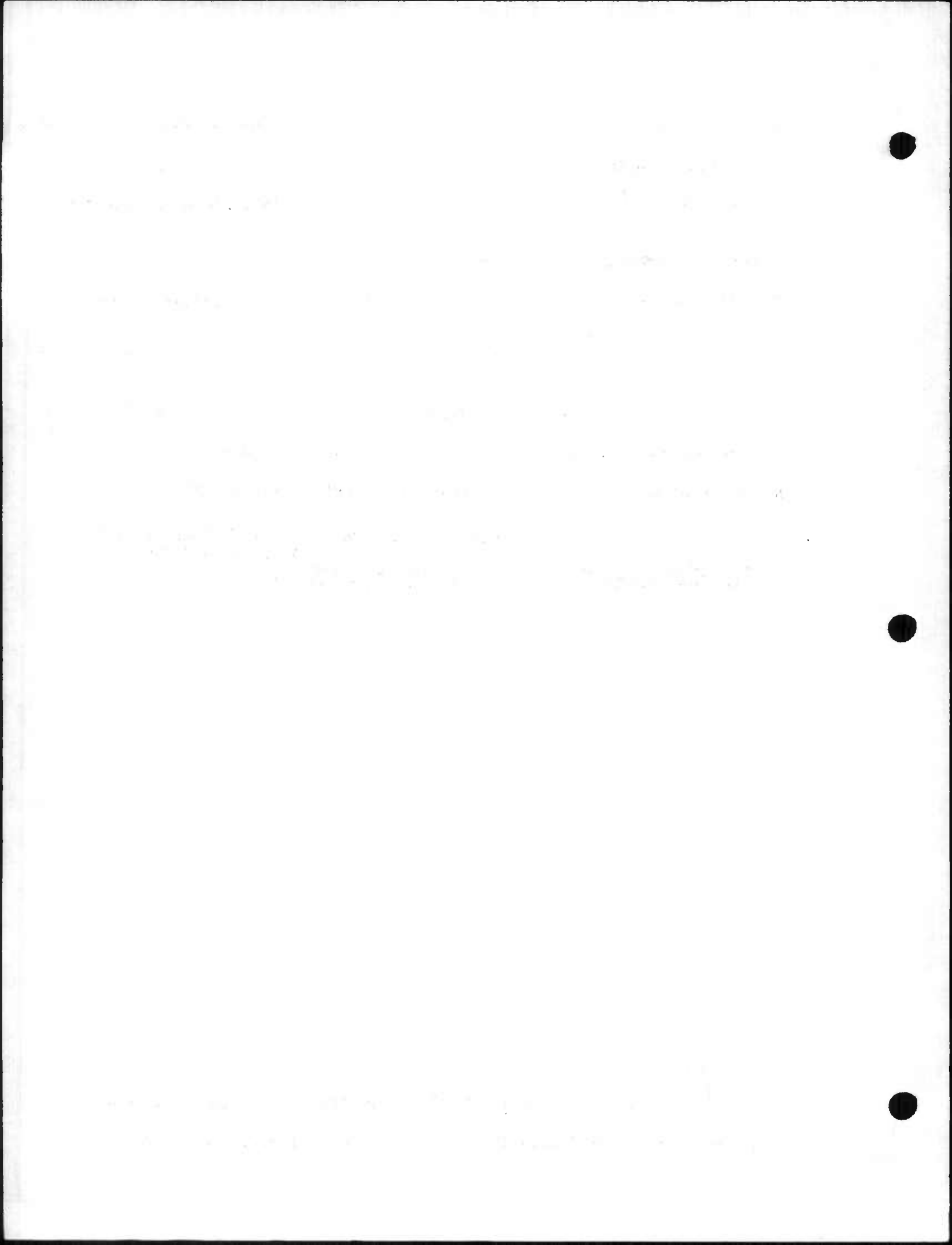
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23334

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Eileen Lorraine Warnock

2. Date of Death

Month Day Year
July 21, 1996

3. Time of Death

9:45am

4a. Facility Name (If not institution, give street and number)

20045 Doolittle Street

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

393-42-1936

6. Sex

1 ☐ M 2 ☒ F
XX

7. Age (In yrs. last birthday)

55

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 2, 1941

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No
A

10e. Street and Number

20045 Doolittle Street

10f. Zip Code

20879

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Henry P. Aykens

18. Mother's Name (First, Middle, Maiden Surname)

Genevieve L. Mueller

19a. Informant's Name/Relationship (Type, Print)

David H. Warnock, Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20045 Doolittle Street, Gaithersburg, MD 20879

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory

Date

7/22/96

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Drive, Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

PANCREATIC CANCER

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

8 MONTHS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, tectory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D32407

29d. Date signed (Month, Day, Year)

July 22, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph M. Haggerty, MD 9707 Medical Center Drive, #300, Rockville, MD 20850

31. Date filed (Month, Day, Year)

JUL 24 1996

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

asp ITEMS: 23 PART I, II, 27,
PER MED FILM g-739 9/6/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23335

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARIE Virginia WALPER		2. Date of Death Month Year JUNE 18 1996		3. Time of Death 7:15A
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL		4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY
Funeral Director	5. Social Security Number 218-20-1342	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	8. Date of Birth (Month, Day, Year) 3/23/1903	9. Birthplace (State or Foreign Country) Mass.
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10e. State Md.	10b. County Montgomery	10c. City, Town or Location Gaithersburg		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 8204 Goodhurst Drive		10f. Zip Code 20882		10g. Citizen of What Country? U.S.A.
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Realtor		16b. Kind of Business/Industry Realestate
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Ignazio Messina		18. Mother's Name (First, Middle, Maiden Surname) Antonina Buccheri		
	19a. Informant's Name/Relationship (Type, Print) Rajinder Johal/ Friend		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8204 Goodhurst Drive Gaithersburg, Md. 20882		
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven		20c. Location - City or Town, State 7/22/96 Silver Spring, Md.
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877		
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PULMONARY THROMBOEMBOLISM DUE TO DEEP VEIN THROMBOSIS OF RIGHT LEG Due to (or as a consequence of): COMPLICATING RIGHT LUNG PNEUMONIA Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred		
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) JUNE 27, 1996
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore M. King 111 Penn Street, Baltimore, Maryland 21201				
State Registrar	31. Date filed (Month, Day, Year) JUL 24 1996		32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23336

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Harley William Weakley				2. Date of Death Month July Day 24 Year 1996		3. Time of Death 10 00 AM	
	4a. Facility Name (If not institution, give street and number) 808 Silver Spring Avenue				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 214-03-9268		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 21, 1910	9. Birthplace (State or Foreign Country) Virginia
	Usual Residence of Decedent							
10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 808 Silver Spring Avenue				10f. Zip Code 20910		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Montgomery County Government		
17. Father's Name (First, Middle, Last) Acre Winfield Weakley				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Susan Broyles				
19a. Informant's Name/Relationship (Type, Print) Elisabeth L. Weakley				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 116 Eastmoor Drive, Silver Spring, MD 20901				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Burtonsville Union Cemetery		20c. Location - City or Town, State Burtonsville, Maryland				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. West Silver Spring, MD 20901				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. acute myocardial infarction Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 6 mos
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number 208546		29d. Date signed (Month, Day, Year) July 25-1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Tauber 8218 Wisconsin Ave Bethesda								
31. Date filed (Month, Day, Year) JUL 26 1996				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

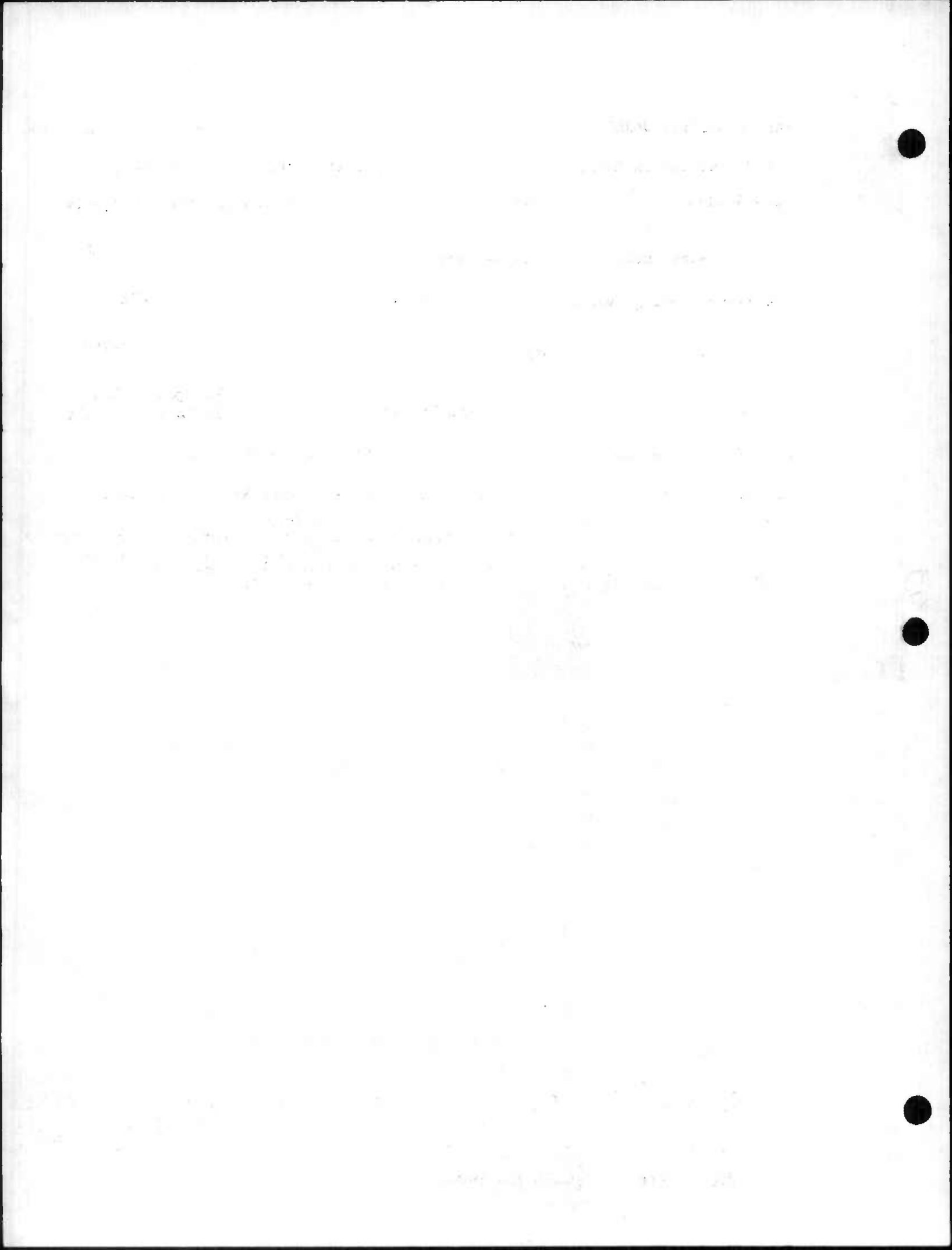
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

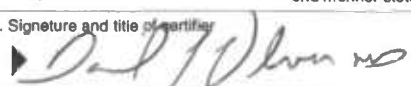

State of Maryland / Department of Health and Mental Hygiene

96 23337

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Henry E. Wright				2. Date of Death Month July Day 22 Year 1996		3. Time of Death 9:10pm														
	4a. Facility Name (If not institution, give street and number) Memorial Hospital at Easton				4b. City, Town, or Location of Death Easton		4c. County of Death Talbot														
Funeral Director	5. Social Security Number 196-26-6965		6. Sex MM 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 25, 1910														
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Queen Annes		10c. City, Town or Location Queenstown														
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 838 Arrington Road		10f. Zip Code 21658		10g. Citizen of What Country? USA														
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black														
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic		16b. Kind of Business/Industry Domestic																
	17. Father's Name (First, Middle, Last) John Frank Wright				18. Mother's Name (First, Middle, Maiden Surname) Alice Coleman																
	19a. Informant's Name/Relationship (Type, Print) Lillie M. Wright				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 838 Arrington Road, Queenstown, Md. 21658																
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesterfield Cemetery		20c. Date 7/27/96		20d. Location - City or Town, State Centreville, Md.														
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Bennie Smith Funeral Home P.O. Box 1687, Easton, Md. 21601																
	23a. Part I. Enter the cause or causes of death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Pneumonia</td> <td>Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death 10 d</td> </tr> <tr> <td>b. metastatic gastric malignancy</td> <td>Due to (or as a consequence of):</td> <td>10 d</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	Due to (or as a consequence of):	Approximate Interval Between Onset and Death 10 d	b. metastatic gastric malignancy	Due to (or as a consequence of):	10 d	c.	Due to (or as a consequence of):		d.	Due to (or as a consequence of):	
	Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	Due to (or as a consequence of):	Approximate Interval Between Onset and Death 10 d																	
b. metastatic gastric malignancy		Due to (or as a consequence of):	10 d																		
c.		Due to (or as a consequence of):																			
d.		Due to (or as a consequence of):																			
<table border="1"> <tr> <td colspan="4">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pulmonary fibrosis</td> </tr> <tr> <td colspan="4">23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="2">24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="2">24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> </table>								Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pulmonary fibrosis				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pulmonary fibrosis																					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																			

25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number D39749		29d. Date signed (Month, Day, Year) 7/25/96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David G. Oliver, M.D., 503 Dutchman's Lane, Easton, Md 21601									
31. Date filed (Month, Day, Year) JUL 26 1996				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

East

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23338

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Horace Melvin Wilson						2. Date of Death Month Day Year July 20, 1996		3. Time of Death 8:00 PM			
	4a. Facility Name (If not institution, give street and number) 133 Sawmill Lane						4b. City, Town, or Location of Death Grasonville		4c. County of Death Queen Annes			
Funeral Director	5. Social Security Number 219-03-7667		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) Mar. 10, 1913		9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State Maryland		10b. County Queen Annes		10c. City, Town or Location Grasonville				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street end Number 133 Sawmill Lane				10f. Zip Code 21638		10g. Citizen of What Country? USA					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waterman			16b. Kind of Business/Industry Waterman				
	17. Father's Name (First, Middle, Last) William Randall						18. Mother's Name (First, Middle, Maiden Surname) Beulah M. Wilson					
	19a. Informant's Name/Relationship (Type, Print) Julia Ann Wilson						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 135 Sawmill Lane, Grasonville, Md. 21638					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Bryan's Church Cemetery			Date 7/24/96		20c. Location - City or Town, State Grasonville, Md.			
	21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Bennie Smith Funeral Services P.O. Box 1687, Easton, Md. 21601					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>Congestive Heart failure</u> Due to (or as a consequence of): b. <u>Arteriosclerotic Heart disease</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death Uncertain	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Chronic Lymphatic Leukemia</u>										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier <u>Robert W. Trever, M.D.</u>		
										29c. License number D10938		
										29d. Date signed (Month, Day, Year) July 22, 1996		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Robert W. TREVER, M.D. 7696 Ocean Gateway, Easton, MD 21601												
31. Date filed (Month, Day, Year) JUL 24 1996				32. Registrar's Signature <u>Lelia Davidson-Randall</u>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 23339

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) AUSLEE WILLIAM WARNER JR.				2. Date of Death Month JULY Day 16 , Year 1996		3. Time of Death 2:45 PM	
	4a. Facility Name (If not institution, give street and number) WHITEMARSH ROAD (FARM LANE)				4b. City, Town, or Location of Death TRAPPE		4c. County of Death TALBOT	
Funeral Director	5. Social Security Number 214-42-8028		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 50 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) FEB. 20, 1946	9. Birthplace (State or Foreign Country) MD.
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD.		10b. County TALBOT		10c. City, Town or Location TRAPPE			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 29268 BACKTOWN RD.				10f. Zip Code 21673		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 69-72		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PRODUCTION WORKER			16b. Kind of Business/Industry COLDWATER SEAFOOD		
	17. Father's Name (First, Middle, Last) AUSLEE W. WARNER, SR.				18. Mother's Name (First, Middle, Maiden Surname) MARY ELIZABETH BROWN			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) CHIQUITA WARNER/ WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29145 SANDERSTOWN RD. TRAPPE, MD. 21673			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) paradise cemetery		Date 7/20/96		20c. Location - City or Town, State TRAPPE, MD.	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility WILLIAMSON-FLUHARTY FUNERAL SERVICE, P.A. 319 E. DOVER ST. EASTON, MD. 21601			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Gunshot Wound to Head</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) ROADWAY						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) Found 7/16/96		28b. Time of Injury 2pm M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred Subject shot self
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) vehicle on roadway						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier 				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) JULY 17, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) JUL 22 1996		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1861. It is a very important document, as it is the first official communication of the new President to the Congress.

2. The second part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it is the first official communication of the new President to the Congress.

3. The third part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it is the first official communication of the new President to the Congress.

4. The fourth part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it is the first official communication of the new President to the Congress.

5. The fifth part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it is the first official communication of the new President to the Congress.

6. The sixth part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it is the first official communication of the new President to the Congress.

7. The seventh part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it is the first official communication of the new President to the Congress.

8. The eighth part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it is the first official communication of the new President to the Congress.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23340

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SAN YEE		2. Date of Death Month July Day 17 Year 1996		3. Time of Death 1:34 AM
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL		4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY
Funeral Director	5. Social Security Number None	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Aug. 7, 1923		9. Birthplace (State or Foreign Country) Burma		
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number 1110 Veirs Mill Road		10f. Zip Code 20851		10g. Citizen of What Country? Burma
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Asian				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home
	17. Father's Name (First, Middle, Last) Tun Hlaing		18. Mother's Name (First, Middle, Maiden Surname) Daw Aye		
	19a. Informant's Name/Relationship (Type, Print) Sandee Pyne/Grand daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1110 Veirs Mill Road, Rockville, Maryland 20851		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.		20c. Location - City or Town, State Bethesda, Maryland
	21. Signature of Funeral Service Licensee Randy [Signature] M00198		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYO CARDIAC INFARCTION Due to (or as a consequence of): b. ACUTE CHF Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 1 day 1 day
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier [Signature] ATTENDING PHYSICIAN		29c. License number D 43869		29d. Date signed (Month, Day, Year) JULY 17, 1996	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11908 DARNESTOWN RD., SUITE D, NORTH POTOMAC, MD 20878					
31. Date filed (Month, Day, Year) JUL 23 1996		32. Registrar's Signature [Signature]			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Certificate of Death

Reg. No.

96 23341

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HOWARD ANDERSON JR.

2. Date of Death

JULY 27, 1996

3. Time of Death

2103 PM

4a. Facility Name (If not institution, give street and number)

BON SECOUR HOSPITAL E.R.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

217-66-6517

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

38 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 25, 1957

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2424 W. Franklin Street

10f. Zip Code

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)
12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Home Improvement

16b. Kind of Business/Industry

Self-Employed

17. Father's Name (First, Middle, Last)

Howard E. Anderson Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Ann Jones

19a. Informant's Name/Relationship (Type, Print)

Ann Stewart

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2424 W. Franklin St., Baltimore, Maryland 21223

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

WOODLAWN CEMETERY

Date

8-2-96

20c. Location - City or Town, State

WOODLAWN, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Joseph H. Brown Jr. Funeral Home
2140 N. Fulton Ave., Baltimore, Maryland 21217

23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. ACUTE NARCOTIC AND COCAINE INTOXICATION

Due to (or as a consequence of):

Sequitely list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE

HYPERTENSIVE CARDIOVASCULAR DISEASE

SEIZURE DISORDER

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy
performed?

☒ Yes ☐ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

☐ Yes ☒ No

25. Was case referred to medical
examiner?

☒ Yes ☐ No

Hospital:

☐ Inpatient

☒ Outpatient

☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending
investigation
☐ Accident ☒ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury
(Month, Day Year)

FOUND 7-27-96

28b. Time of
Injury

UNKNOWN M

28c. Injury at
Work?

☐ Yes ☒ No

28d. Describe how Injury occurred

UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

FOUND AT HOME

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

2424 W. FRANKLIN ST.
BALTIMORE, MARYLAND

29a. Certifier
(Check only
one)

☐ Certifying Physician

☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

JULY 28, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 07 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23342

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KELVIN L. BENNETT		2. Date of Death Month Day Year AUG. 03, 1996		3. Time of Death 0333 AM
	4a. Facility Name (If not institution, give street and number) SUBURBAN HOSPITAL		4b. City, Town, or Location of Death BETHESDA		4c. County of Death MONTGOMERY
Funeral Director	5. Social Security Number 298-48-7730	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 44 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth Month Day Year 04/03/1952		9. Birthplace (State or Foreign Country) Ohio		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State MD.	10b. County Prince Georges	10c. City, Town or Location Hyattsville		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 7813 Burnside Rd.		10f. Zip Code 20785		10g. Citizen of What Country? U.S.A.
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) +2		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Carpentry		
	17. Father's Name (First, Middle, Last) George Kenneth Bennett		18. Mother's Name (First, Middle, Maiden Surname) Daisy A. Jackson		
	19a. Informant's Name/Relationship (Type, Print) Daisy A. Bennett/ Mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 543 Cohasset Dr. Youngstown, OH. 44511		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Tod Homestead		20c. Location - City or Town, State 8/8/96 Youngstown, OH.
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Sterling Ashton Funeral Home, Inc. 736 Edmondson Ave. Balto. MD. 21228		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 8/3/96		
	28b. Time of Injury 0045 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	28d. Describe how injury occurred subject pedestrian struck by vehicle		28e. Location (Street and Number or Rural Route Number, City or Town, State) Kenilworth Avenue, Prince Georges County		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		
	29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) AUG. 3, 1996		
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Theodore M. King		31. Date filed (Month, Day, Year) AUG 07 1996		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

THE STATE OF TEXAS,
COUNTY OF DALLAS.I, the undersigned, a Notary Public in and for the State of Texas, do hereby certify that the within and foregoing is a true and correct copy of the original of the same, as the same appears from the records of the County of Dallas, State of Texas.GIVEN UNDER MY HAND AND SEAL OF OFFICE, this 1st day of May, 1901.

[Handwritten signature]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23343

ITEM# 19b&22 film g738 8/7/96ag perFH

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

MARY LOU BRENNAN

2. Date of Death

Aug 7 1996

3. Time of Death

5:00 P.M.

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSP, 5601 LOCH RAVEN

4b. City, Town, or Location of Death

BALTO, MD

4c. County of Death

N/A

5. Social Security Number

254-32-9106

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 4, 1920

9. Birthplace (State or Foreign Country)

OHIO

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

TOWSON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

900 Fairmount Ave.

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Occupational Therapist

18b. Kind of Business/Industry

Occupational Therapy

17. Father's Name (First, Middle, Last)

Elmore Kurt Walther

18. Mother's Name (First, Middle, Maiden Surname)

Mary Potter

19a. Informant's Name/Relationship (Type, Print)

Thomas Bennett Brennan

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

900 Fairmount Ave., Towson, MD 21204 21286

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery

Date

AUG 8

20c. Location - City or Town, State

Pikesville, MD

21. Signature of Funeral Service Licensee

Bryan W. Clary

22. Name and Address of Facility

Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypoxia - severe

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

24 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Pneumonia

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHF

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D.

D47065

29c. License number

29d. Date signed (Month, Day, Year)

August 7, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARIE JEAN T. MACARUBBO, 5601 LOCH RAVEN BLVD, BALTO, MD 21239

31. Date filed (Month, Day, Year)

AUG 07 1996

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23344

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Myrtle Bayne</i>				2. Date of Death Month <i>August</i> Day <i>1</i> Year <i>1996</i>		3. Time of Death <i>10:10 AM</i>	
	4a. Facility Name (If not Institution, give street and number) <i>Meridian Franklin Woods Center</i>				4b. City, Town, or Location of Death <i>Rosedale</i>		4c. County of Death <i>Baltimore</i>	
Funeral Director	5. Social Security Number <i>212-36-4323</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>89</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>April 5, 1907</i>	9. Birthplace (State or Foreign Country) <i>Virginia</i>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <i>Maryland</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Edgemere</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <i>7001 North Point Road</i>				10f. Zip Code <i>21219</i>		10g. Citizen of What Country? <i>United States</i>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>12 Years</i>		College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Teller</i>		16b. Kind of Business/Industry <i>Banking</i>	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <i>Joseph Webb</i>				18. Mother's Name (First, Middle, Maiden Sumama) <i>Unknown</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Mr. Patrick Cavanaugh (Attorney)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>25 Shipping Place Baltimore, Maryland 21222</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Gardens of Faith Cem. 8/5/1996</i>		20c. Location - City or Town, State <i>Rossville, Maryland</i>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Baltimore, Maryland 21222</i>			
Physician /Medical Examiner	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	Immediate Cause (Final disease or condition resulting in death) a. <i>Acute Myocardial Infarction</i> hours							
	Due to (or as a consequence of): b. <i>Atherosclerotic Cardiovascular Disease</i> years							
	Due to (or as a consequence of): c. <i>Probable Fungal sepsis</i> week							
Due to (or as a consequence of): d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Acute upper GI bleeding,</i> <i>Autoimmune hemolytic anemia</i> <i>Dementia.</i>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <i>[Signature]</i>						
29c. License number <i>D33943</i>		29d. Date signed (Month, Day, Year) <i>8-1-96</i>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Susan Levy N.D. Franklin Square Hospital</i>								
31. Date filed (Month, Day, Year) <i>AUG 07 1996</i>								

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 37 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23346

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Peter D. Caloger				2. Date of Death Month Day Year July 29 96				3. Time of Death 8 AM						
	4a. Facility Name (If not institution, give street and number) Greater Baltimore Medical Center				4b. City, Town, or Location of Death Towson				4c. County of Death Baltimore						
Funeral Director	5. Social Security Number 352-09-4107		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) 11/01/1907		9. Birthplace (State or Foreign Country) Illinois						
	Usual Residence of Decedent														
To Be Completed by Funeral Director	10a. State MD.		10b. County Baltimore		10c. City, Town or Location Glyndon				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	10e. Street and Number 11 Worthington Hill Dr.				10f. Zip Code 21071		10g. Citizen of What Country? U.S.A.								
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) +8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Attorney				16b. Kind of Business/Industry Administrative Law						
	17. Father's Name (First, Middle, Last) Dennis George Caloger				18. Mother's Name (First, Middle, Maiden Surname) Aspasia Stavrou										
	19a. Informant's Name/Relationship (Type, Print) Eleutheria Caloger/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Worthington Hill Dr. Glyndon, MD. 21071										
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date 8/2/96		20c. Location - City or Town, State Beltsville, MD.								
	21. Signature of Funeral Service Licensee Edward A. Gresham				22. Name and Address of Facility Bradley-Ashton Funeral Home, Inc. 2134 Willow Spring Rd. Balto., MD. 21222										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Peritonitis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death 1 WK				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
										24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier John W. Bowie MD		29c. License number D20649		29d. Date signed (Month, Day, Year) 7/31/96	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JOHN W. BOWIE, M.D. 6800 YORK RD. BALTIMORE, MD. 21212															
31. Date filed (Month, Day, Year) AUG 07 1996		32. Registrar's Signature Julia Davidson-Randall													

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23347

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gerard Vernon Caldwell				2. Date of Death Month August 4, Day 1996 Year				3. Time of Death 12:45 AM		
	4a. Facility Name (If not institution, give street and number) Franklin Woods Meridian				4b. City, Town, or Location of Death Rossville				4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 216-12-7786		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) August 2, 1919		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent				10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore		
To Be Completed by Funeral Director	10e. Street and Number 4819 King Avenue		10f. Zip Code 21236-3811		10g. Citizen of What Country? U.S.A.		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Lawyer		16b. Kind of Business/Industry Law Firm						
	17. Father's Name (First, Middle, Last) William Thomas Caldwell				18. Mother's Name (First, Middle, Maiden Surname) Henrietta Margaret Thiess						
	19a. Informant's Name/Relationship (Type, Print) Marietta F. Adamo				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12938 Harford Road Hydes, Maryland 21082						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cemetery		20c. Location - City or Town, State Baltimore, Maryland						
	21. Signature of Funeral Service Licensee <i>John J. Dippel</i>				22. Name and Address of Facility The Dippel Funeral Home Inc. 7110 Belair Road Baltimore, Maryland 21206						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Acute Myocardial Infarction</i> Due to (or as a consequence of): b. <i>Congestive Heart Failure</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 6 weeks 6 weeks						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Atrial Fibrillation</i> <i>Stroke with Hemiplegia & Aphasia</i>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>N. Deshpande MD</i>		29c. License number D 460 82		29d. Date signed (Month, Day, Year) 8/15/96					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEETA DESHPANDE M.D. 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237				31. Date filed (Month, Day, Year) AUG 07 1996				32. Registrar's Signature <i>John J. Dippel</i>			

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23348

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Annie May Duvall				2. Date of Death Month August Day 5 Year 1996		3. Time of Death 4:30 AM			
	4a. Facility Name (If not institution, give street and number) Windsor Ridge Nursing Home				4b. City, Town, or Location of Death Randallstown		4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 215-28-9354		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 11, 1930	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Md.		10b. County Baltimore		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 8542 Dogwood Road				10f. Zip Code 21207		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th		College (1-4 or 5+) -0-		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Walter Humple				18. Mother's Name (First, Middle, Maiden Surname) Daisy Grimm					
	19a. Informant's Name/Relationship (Type, Print) Carlisle Duvall / husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 167 Klees Mill Rd. Sykesville, Md. 21784					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Paran Cemetery		Date 8-8-96		20c. Location - City or Town, State Randallstown, Md.			
	21. Signature of Funeral Service Licensee E. Brian Powell				22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, Md. 21136					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACUTE RENAL FAILURE Due to (or as a consequence of): END STAGE RENAL DISEASE Due to (or as a consequence of): DIABETES MELLITUS Due to (or as a consequence of): Immediata Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 5 DAYS 24 YEARS 4 YEARS	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. C. V. A								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier B. C. Veneracion Jr MD		29c. License number D13664		29d. Date signed (Month, Day, Year) 8/5/96				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. C. VENERACION JR MD 1576 KERRITT BLVD BALTO MD 21222										
31. Date filed (Month, Day, Year) AUG 07 1996		32. Registrar's Signature Windsor								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

96 23349

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Elizabeth M DIBBERN</i>				2. DATE OF DEATH MONTH DAY YEAR <i>August 06 1996</i>		3. TIME OF DEATH <i>0358 A M</i>	
4. SOCIAL SECURITY NUMBER <i>216-54-1454</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>84</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>07/26/1912</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Lorian Nursing Home</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH <i>N/A</i>	
10a. STATE <i>MD.</i>		10b. COUNTY <i>N/A</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>5 N. Curley St.</i>				10f. ZIP CODE <i>21224</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8th</i> College (1-4 or 5+) <i></i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Charles J. Gorman, Sr.</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Rosa Leidner</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Brenda Johns/Daughter</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3618 Conowingo Rd. Street, MD. 21154</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Oak Lawn Cemetery 8/10</i>		20c. LOCATION — City or Town, State <i>Baltimore, MD.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edna A. Jell</i>				22. NAME AND ADDRESS OF FACILITY <i>Moran-Ashton Funeral Home, Inc. 3000 E. Balto. St. Balto., MD. 21224</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Atherosclerotic Cardio Vascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF):					
		b. <i>Actual fibrillation</i> DUE TO (OR AS A CONSEQUENCE OF):					
		c. <i></i> DUE TO (OR AS A CONSEQUENCE OF):					
		d. <i></i> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Renal Insufficiency</i> <i>Gastrointestinal Bleeding</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE NOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Fredric S. Sirkis M.D.</i>				29c. LICENSE NUMBER <i>D 22045</i>		29d. DATE SIGNED (Month, Day, Year) <i>8/6/96</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>FREDRIC S. SIRKIS M.D. 7151 HOLABIRD AVE. BALTO. MD. 21222</i>							
31. DATE-FILED (Month, Day, Year) <i>AUG 07 1996</i>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23350

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Clara Dominiak				2. Date of Death Month August Day 5 , 1996 Year 1996				3. Time of Death 1:45		
	4a. Facility Name (If not institution, give street and number) 402 Hillside Drive				4b. City, Town, or Location of Death New Windsor				4c. County of Death Carroll		
Funeral Director	5. Social Security Number 213-01-6496		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) 09/01/1913		9. Birthplace (State or Foreign Country) Maryland		
	10a. State MD.				10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 26 S. Decker Ave.				10f. Zip Code 21224				10g. Citizen of What Country? U.S.A.			
11. Marital Status <input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4th				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assembly worker				16b. Kind of Business/Industry Bag Manufacturer			
17. Father's Name (First, Middle, Last) Francis Dominiak				18. Mother's Name (First, Middle, Maiden Surname) Maryanna Czaja							
19a. Informant's Name/Relationship (Type, Print) Nancy LeBrun/ Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 Hillside Dr. P.O. Box 126 New Windsor, MD. 21776							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Stanislaus Cem.				Date 8/8/96		20c. Location - City or Town, State Baltimore, MD.	
21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility Moran-Ashton Funeral Home, Inc. 3000 E. Balto. St. Balto., MD. 21224							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Congestive heart failure days Due to (or as a consequence of): cardiomyopathy years diabetes mellitus years										Approximate Interval Between Onset and Death	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Ephraim Barzaga				29c. License number D14992		29d. Date signed (Month, Day, Year) 8-5-96	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EPHRAIM BARZAGA NEW WINDSOR, MD. 21776											
31. Date filed (Month, Day, Year) AUG 07 1996										Registrar's Signature [Signature]	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Film G738 iten 8 per FH 8-22-96 rja

State of Maryland / Department of Health and Mental Hygiene

96 23351

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HUNTER C DODSON				2. Date of Death Month August Day 06 Year 1996		3. Time of Death 8:00 A.M.		
	4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL Hospital				4b. City, Town, or Location of Death Glen Burnie		4c. County of Death ANNE ARUNDEL		
Funeral Director	5. Social Security Number 224-10-0849		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 1-7-10 Jan. 10, 1910	9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Glen Burnie		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 930 Andrews Road				10f. Zip Code 21060		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1926 1931		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Park Ranger		16b. Kind of Business/Industry U.S. National Park				
	17. Father's Name (First, Middle, Last) Unknown				18. Mother's Name (First, Middle, Maiden Surname) Unknown				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Margaret Dodson/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 930 Andrews Rd. Glen Burnie, MD 21060				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crownsville MD Veterans		Date Aug. 9, 1996		20c. Location - City or Town, State Crownsville, MD		
	21. Signature of Funeral Service Licensee Paul Ebaugh				22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Hwy. S.E. Glen Burnie, MD 21061				
	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MYOCARDIAL INFARCTION. PNEUMONIA. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE PULMONARY FIBROSIS						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier MD		29c. License number D43977		29d. Date signed (Month, Day, Year) AUGUST 06 1996			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Unknown ORETHING, 301 HOSPITAL DRIVE, GLEN BURNIE MD 21061									
31. Date filed (Month, Day, Year) AUG 07 1996		32. Registrar's Signature Schaefer							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23352

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) Donald Alexander Davis				2. Date of Death Month August Day 5 Year 1996		3. Time of Death 13:37			
	4a. Facility Name (If not institution, give street and number) Fallston General Hospital				4b. City, Town, or Location of Death Fallston		4c. County of Death Harford			
Funeral Director	5. Social Security Number 044-38-9114		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 47 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec 12, 1948	9. Birthplace (State or Foreign Country) Massachusetts		
	Usual Residence of Decedant									
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Perry Hall			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 43 Benn Way				10f. Zip Code 21236		10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedant Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1968-72		13. Was Decedant of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Proprietor			16b. Kind of Business/Industry Cabinet Designing			
17. Father's Name (First, Middle, Last) Frank Western Davis, Jr.				18. Mother's Name (First, Middle, Maiden Surname) Janet Marie Greenwood						
19a. Informant's Name/Relationship (Type, Print) Janet G. Auerbach				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2102 Dalewood Court, Timonium, MD 21093						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Memorial Park		Date Aug 8		20c. Location - City or Town, State Baltimore, Maryland				
21. Signature of Funeral Service Licensee Bryan W. Clary				22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD 21093						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebellar infarction w. Pons Sable 2 days b. brain stem herniation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. d.									Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
							24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier [Signature]		29c. License number 1028339		29d. Date signed (Month, Day, Year) August 5, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LINDA FINEKUTT 101 E. Wheel Road Bel Air MD 21011										
31. Date filed (Month, Day, Year) AUG 07 1996				32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

Baltimore, Maryland 21215-0020
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23353

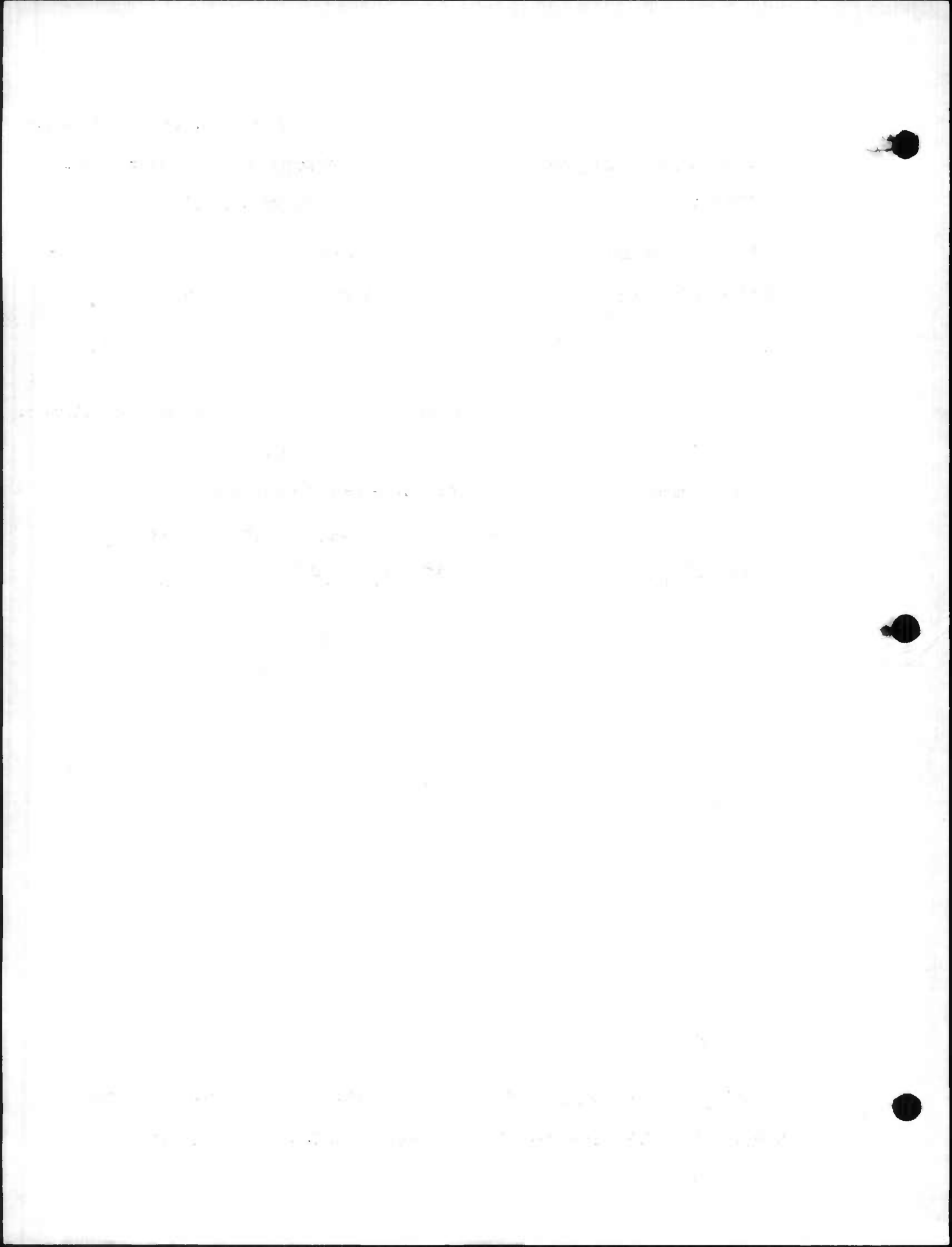
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Doris Helen DORN				2. Date of Death Month August Day 5 Year 1996		3. Time of Death 11:40 a.m.	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital				4b. City, Town, or Location of Death Rossville		4c. County of Death Baltimore County	
Funeral Director	5. Social Security Number 212-60-2616		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 9, 1917	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Md.		10b. County Baltimore		10c. City, Town or Location Essex	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 2235 Corsica Road		10f. Zip Code 21221	
	10g. Citizen of What Country? USA				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) 9th Elementary/Secondary (0-12) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Quality Control		16b. Kind of Business/Industry Carr-LowereyGlassCo.	
	17. Father's Name (First, Middle, Last) Fred Long				18. Mother's Name (First, Middle, Maiden Surname) Helen Herr			
	19a. Informant's Name/Relationship (Type, Print) Joyce Johnston				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 304 Torner Road Baltimore Md. 21221			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cemetery		20c. Location - City or Town, State 8/8/96 Rossville Md.	
	21. Signature of Funeral Service Licensee <i>R. Terry Connelly</i>				22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mce Ave. Baltimore Md. 21221			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last e. Congestive Heart Failure Due to (or as a consequence of): b. Arrhythmia Due to (or as a consequence of): c. Acute Renal Failure Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 27 Days							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pulmonary Edema				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		
				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Kristin M. Clark MD</i>				
				29c. License number RD 2098		29d. Date signed (Month, Day, Year) August 5, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kristin Clark M.D. 9000 Franklin Square Drive Baltimore, MD 21237				31. Date Filed (Month, Day, Year) AUG 07 1996				
				32. Registrar's Signature <i>Julia Paulson-Randall</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23354

Certificate of Death

Reg. No.

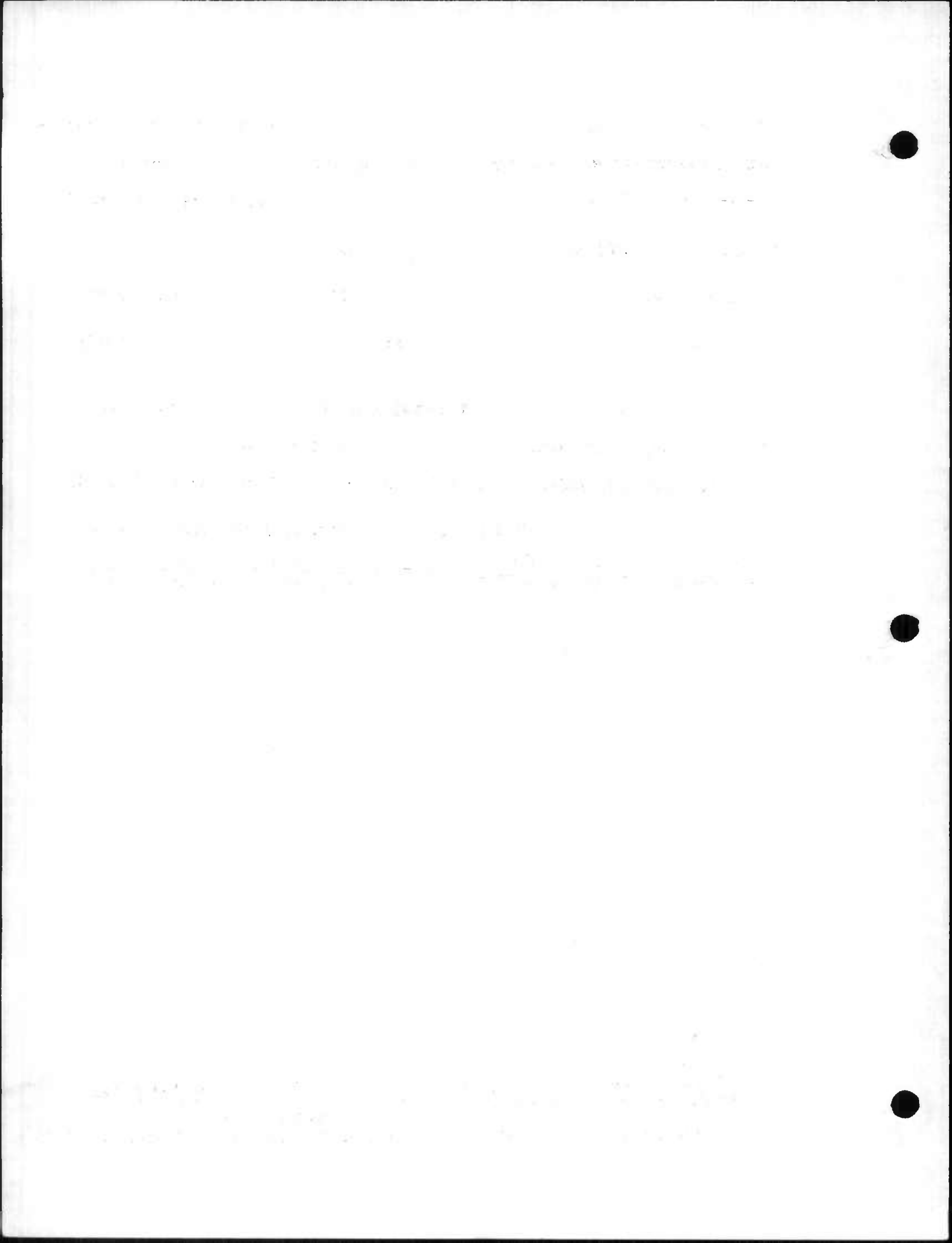
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY AGNES ERDINC				2. Date of Death Month AUGUST Day 3 Year 1996		3. Time of Death 2:15 pm		
	4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 218-82-3243	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 35 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 29, 1960		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Dundalk			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 613 48th Street			10f. Zip Code 21224		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Personnel Specialist		16b. Kind of Business/Industry Baltimore County				
	17. Father's Name (First, Middle, Last) Robert Anthony Kaschenbach				18. Mother's Name (First, Middle, Maiden Surname) Annette Bartkowiak				
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Sharon L. Kaschenbach/Sister			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3147 Sykesville Road Westminster, MD 21157					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Ht. of Jesus Cem.		Data 8/7/1996		20c. Location - City or Town, State Dundalk, Maryland		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Carcinoma of pancreas								
	23b. Part II. Enter the date, or dates, of onset of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6 mo								
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  BREITENECKER		29c. License number D-00725		29d. Date signed (Month, Day, Year) 8/4/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rudiger Breitenecker 6701 N. Charles St. Baltimore, MD 21204				31. Date filed (Month, Day, Year) AUG 07 1996					

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23355

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MITCHELL SUELL EVANS SR.

2. Date of Death

06 02 1996

3. Time of Death

9:26am

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

219-70-0250

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

32 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

06-14-1964

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

817 STOLL STREET

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9 YRS.

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DISABLED

16b. Kind of Business/Industry

DISABLED

17. Father's Name (First, Middle, Last)

EDWARD S. EVANS JR.

18. Mother's Name (First, Middle, Maiden Surname)

DOLLIE BENNETT

19a. Informant's Name/Relationship (Type, Print)

RUTH ANN EVANS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

906 N. BOONE JOHNSON CITY, TN. 37601.

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MORRIS-BAKER F. HOME

Date

8/6/96

20c. Location - City or Town, State

JOHNSON CITY, TN.

21. Signature of Funeral Service Licensee

William R. Davis

22. Name and Address of Facility

HENRY W. JENKINS & SONS CO.
4905 YORK RD. BALTO., MD. 21212.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiomyopathy

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Diabetes

Due to (or as a consequence of):

2 yrs

c. Obesity

Due to (or as a consequence of):

unknown

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 8 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Edward Seidel

29c. License number

038956

29d. Date signed (Month, Day, Year)

August 2, 1996

30. Name and address of person who completed cause of death (item 23e) (Type, Print)

EDWARD SEIDEL HARBOR HOSPITAL CENTER BALTO, MD.

31. Date filed (Month, Day, Year)

AUG 07 1996

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and sequentially filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23356

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES R. FITZ GIBBON JR				2. Date of Death Month AUGUST Day 2 Year 1996		3. Time of Death 7:12 PM		
	4a. Facility Name (If not institution, give street and number) Howard County General Hospital				4b. City, Town, or Location of Death Columbia		4c. County of Death Howard		
Funeral Director	5. Social Security Number 214-46-7124		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Apr. 28, 1948	9. Birthplace (State or Foreign Country) Washington, DC	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD		10b. County Howard		10c. City, Town or Location Columbia			10d. Inade City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 6838 Sewells Orchard Drive				10f. Zip Code 21045		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Police Detective			16b. Kind of Business/Industry Montgomery County Police Department			
	17. Father's Name (First, Middle, Last) James R. FitzGibbon, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Mildred W. Mihm				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Kathleen FitzGibbon (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6838 Sewells Orchard Drive, Columbia, MD 21045				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crestlawn Cemetery		Date Aug. 6, 1996		20c. Location - City or Town, State Marriottsville, MD		
	21. Signature of Funeral Service Licensee <i>Robert S. Brehm</i>				22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd. Columbia, MD 21045				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
	Immediate Cause (Final disease or condition resulting in death) a. Small Cell Carcinoma (R) Lung Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia Pneumonia						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>Maureen L. Freeman</i>				29c. License number D38190		29d. Date signed (Month, Day, Year) AUG 2 1996			
30. Name and address of person who completed Cause of death (Item 23a) (Type, Print) MAUREEN CURRAN MD 10308 B BALTIMORE NAT PIKE ELICOTT CITY MD 21042									
31. Date filed (Month, Day, Year) AUG 07 1996		32. Registrar's Signature <i>Julia Anderson-Randall</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23357

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD FLUDD JR.

2. Date of Death

Month Day Year

08 05 96

3. Time of Death

12:00 NOON

4a. Facility Name (If not institution, give street and number)

(HOME) 1317 WEST SARATOGA STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE, CITY

Funeral
Director

5. Social Security Number

220-09-2545

6. Sex

XXM 2□ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

09-22-1926

9. Birthplace (State or Foreign Country)

SOUTH CAROLINA

10a. State

MARYLAND

10b. County

BALTIMORE, CITY

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

XX Yes 2□ No

10e. Street and Number

1317 WEST SARATOGA STREET

10f. Zip Code

21223

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1□ Never Married 2□ Married

3□ Widowed 4□ Divorced

XX

12. Was Decedent Ever in U.S.

Armed Forces?

1□ Yes 2□ No

If Yes, Give Year or Dates: XX

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2□ No Specify: X

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TRUCK DRIVER

16b. Kind of Business/Industry

ANDERSON TRUCK COMPANY

17. Father's Name (First, Middle, Last)

EDWARD FLUDD SR.

18. Mother's Name (First, Middle, Maiden Surname)

JOSEPHINE MARTIN

19a. Informant's Name/Relationship (Type, Print)

DENISE LEE (FIANCEE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1317 WEST SARATOGA STREET BALTIMORE, MARYLAND 21223

20a. Method of Disposition

1□ Burial 2□ Cremation 3□ Removal from State

4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MOUNT ZION CEMETERY

Date

8/9/1996

20c. Location - City or Town, State

LANSOWNE, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME PA.

1300 EUTAW PLACE BALTIMORE, MARYLAND 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Lung cancer

Due to (or as a consequence of):

3 months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerosis

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2□ No 3□ Probably 4□ Unknown

24a. Was an autopsy performed?

1□ Yes 2□ No

24b. Were autopsy findings available prior to completion of cause of death?

N/A

25. Was case referred to medical examiner?

1□ Yes 2□ No

28. Place of Death (Check only one)

Hospital: 1□ Inpatient 2□ ER/Outpatient 3□ DOA

Other: 4□ Nursing Home 5□ Residence 8□ Other (Specify)

27. Manner of Death

1□ Natural 5□ Pending Investigation

2□ Accident 6□ Could not be determined

3□ Suicide 4□ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1□ Yes 2□ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1□ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

L. Austin Doyle, M.D.

29c. License number

D23809

29d. Date signed (Month, Day, Year)

8/5/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. Austin Doyle, M.D. Univ. of MD Cancer Ctr., 22 S. Greene St., Balt., MD 21201

31. Date filed (Month, Day, Year)

AUG 07 1996

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State
Registrar

1. The first part of the paper is devoted to the study of the properties of the function $f(x)$ defined by the equation

$$f(x) = \int_0^x \frac{1}{1+t^2} dt$$

2. It is well known that the function $f(x)$ is increasing and concave down on the interval $(-\infty, \infty)$.

3. The function $f(x)$ has a horizontal asymptote at $y = \frac{\pi}{2}$ as $x \rightarrow \infty$ and a vertical asymptote at $x = 0$ as $x \rightarrow -\infty$.

4. The function $f(x)$ is continuous and differentiable on the interval $(-\infty, \infty)$.

5. The function $f(x)$ is bounded on the interval $(-\infty, \infty)$.

6. The function $f(x)$ is a solution of the differential equation $y' = \frac{1}{1+x^2}$.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23358

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANCES GORMAN				2. Date of Death Month Day Year AUGUST 03 96		3. Time of Death 04:30 AM	
	4a. Facility Name (If not institution, give street and number) ST. AGNES HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 219-20-8281		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUN 19 1925	
	9. Birthplace (State or Foreign Country) MARYLAND							
Usual Residence of Decedent								
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 526 FOREST LANE				10f. Zip Code 21228		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) 				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OFFICE MANAGER		16b. Kind of Business/Industry CAR DEALERSHIP		
17. Father's Name (First, Middle, Last) EDGAR W. COBB				18. Mother's Name (First, Middle, Maiden Surname) NINA BLANCHE DeNEUFVILLE				
19a. Informant's Name/Relationship (Type, Print) BRIAN GORMAN, SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2906 THORNBROOK RD., ELLICOTT CITY MD 21042				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL		Data 8-6		20c. Location - City or Town, State BALTIMORE, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE., BALT. MD 21228				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC BREAST CANCER Due to (or as a consequence of): b. SEPSIS Due to (or as a consequence of): c. NEUTROPENIA Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Approximate Interval Between Onset and Death a. YEARS b. DAYS c. WEEKS d. 								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D 47014		29d. Date signed (Month, Day, Year) AUGUST, 03, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Hospital (Dr. A. Janicki)								
31. Date filed (Month, Day, Year) AUG 07 1996								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23359

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALVIN GUTENBURG		2. Date of Death Month August Day 06 Year 1996		3. Time of Death 04:55AM
	4a. Facility Name (If not institution, give street and number) Northwest Hospital Center		4b. City, Town, or Location of Death Randallstown		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 500-24-8103	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	8. Date of Birth (Month, Day, Year) July 9, 1925	
	9. Birthplace (State or Foreign Country) Missouri		10. Usual Residence of Decedent		
To Be Completed by Funeral Director	10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Owings Mills		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 214 Midpines Ct. Apt. 1D		10f. Zip Code 21117		10g. Citizen of What Country? U.S.A.
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman		16b. Kind of Business/Industry Jewelry		
	17. Father's Name (First, Middle, Last) Howard Gutenberg		18. Mother's Name (First, Middle, Maiden Surname) Sara Densky		
	19e. Informant's Name/Relationship (Type, Print) Betty Gutenberg - Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 214 Midpines Ct. Apt. 1D, Owings Mills, Md. 21117		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		20c. Location - City or Town, State Baltimore, Md.
	21. Signature of Funeral Service Licensee J. Eckhardt		22. Name and Address of Facility Eckhardt Funeral Chapel 11605 Reisterstown Rd. Owings Mills, Md. 21117		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PNEUMONIA Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined					
28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 06 1996					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) N. Agbogu NORTHWEST HOSP CENTER, BALTO, MD					
31. Date filed (Month, Day, Year) AUG 07 1996					
32. Registrar's Signature 32. Registrar's Signature					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

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State of Maryland / Department of Health and Mental Hygiene

96 23360

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedant's Name (First, Middle, Last)

HARRY

M

GEORGE

2. Date of Death

July 26, 1996

Day

Year

3. Time of Death

3:37AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

City

5. Social Security Number

215-28-0739

6. Sex

M ☒ F

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

Feb. 23, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedant

10a. State

Maryland

10b. County

City

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3727 Foster Avenue

10f. Zip Code

21224

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedant Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedant of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedant's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedant's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Maintenance

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

John S. George

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Brown

19a. Informant's Name/Relationship (Type, Print)

Marie I. George

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3727 Foster Avenue Baltimore, MD 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Good Shepherd Cemetery

Date

July 31

20c. Location - City or Town, State

Ellicott City, MD

21. Signature of Funeral Service Licensee

Catherine M. Zeiler

22. Name and Address of Facility

Lilly & Zeiler, Inc. Funeral Homes
700 S. Conkling Street Baltimore, MD 2122423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Ischemic Cardiomyopathy

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

10 years

b.

Coronary Artery Disease

Due to (or as a consequence of):

20 years

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute Renal Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James A. Underwood MD

29c. License number

M6175

29d. Date signed (Month, Day, Year)

July 26, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J.A. Underwood MD Johns Hopkins Hospital, Baltimore, MD

31. Date filed (Month, Day, Year)

AUG 07 1996

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
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completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

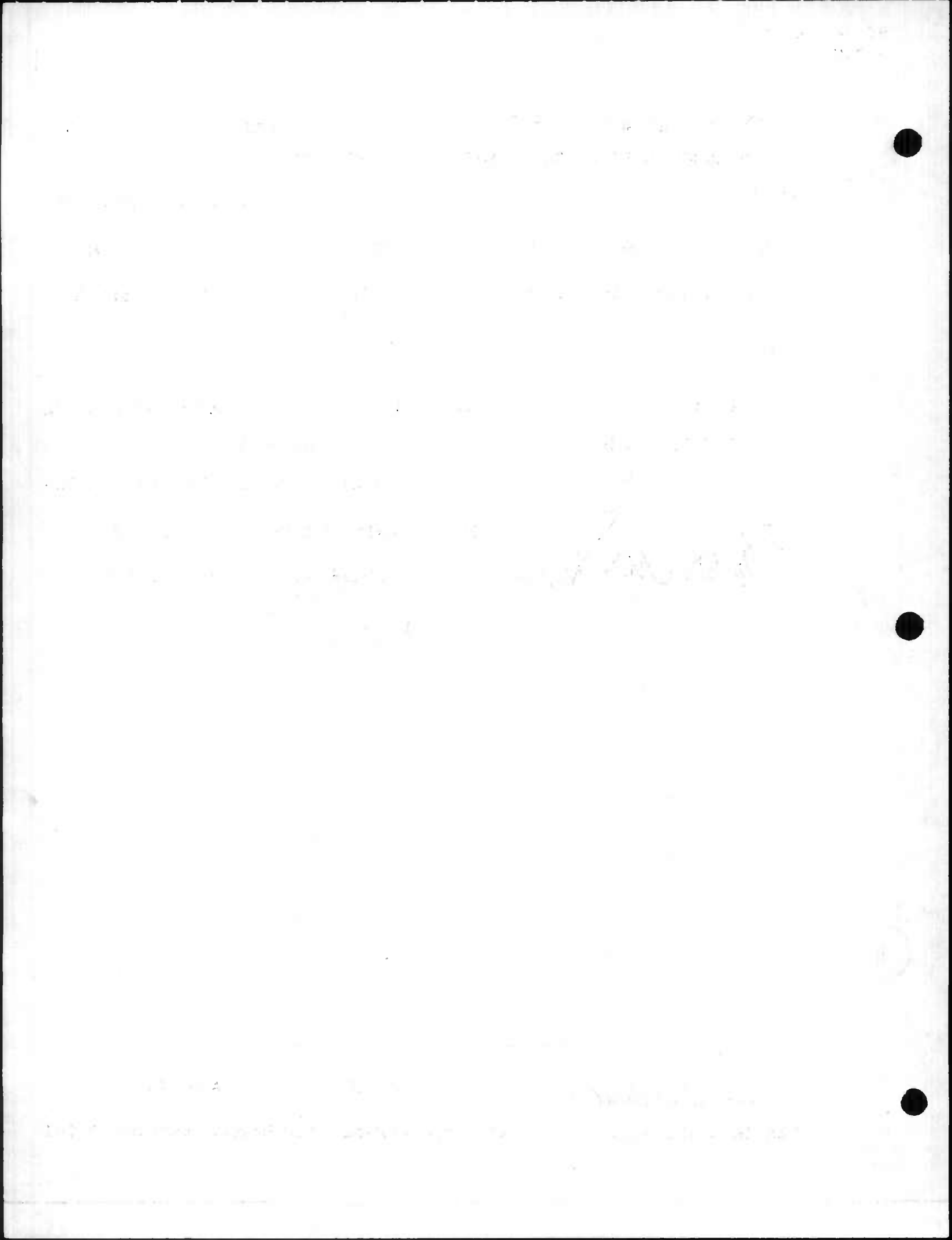
State of Maryland / Department of Health and Mental Hygiene

96 23361

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNIE ELIZABETH HART				2. Date of Death Month AUG. Day 6, Year 1996		3. Time of Death 1105 AM		
	4a. Facility Name (If not institution, give street and number) 1130 NORTH CARROLLTON AVENUE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death n/a		
Funeral Director	5. Social Security Number 077-12-2290		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) OCT. 28, 1916		
	9. Birthplace (State or Foreign Country) BALTIMORE, MD		10a. State MD		10b. County n/a		10c. City, Town or Location BALTIMORE		
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number 1130 N. CARROLLTON AVENUE				10f. Zip Code 21217		10g. Citizen of What Country? UNITED STATES		
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 th College (1-4 or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ASSISTANT		16b. Kind of Business/Industry KESWICK NURSING HOME				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) CHARLES BRAXTON				18. Mother's Name (First, Middle, Maiden Surname) ANNIE ASBY				
	19a. Informant's Name/Relationship (Type, Print) ANNIE BRAXTON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1130 N. CARROLLTON AVENUE, Baltimore, md 21217				
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) VOSHALL MEMORIAL GARDENS 8-12 DUNDALK, MD		20c. Location - City or Town, State				
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility WM. C. MARCHFH.-1101 E. NORTH AVENUE						
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? INSPECTION <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier 				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) AUG. 6, 1996		
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201								
	31. Date filed (Month, Day, Year) AUG 07 1996				32. Registrar's Signature 				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23362

Item 4c, Film 738, 8/7/96, 1t

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) AGNES HOLLIS				2. Date of Death Month AUGUST Day 4th Year 1996				3. Time of Death 5:57 PM											
	4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL CENTER				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death BALTIMORE CITY		4d. n/a									
Funeral Director	5. Social Security Number 212-42-1357		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 52 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 7, 1943		9. Birthplace (State or Foreign Country) Maryland											
	Usual Residence of Decedent																			
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
	10e. Street and Number 1950 Guy Way				10f. Zip Code 21222		10g. Citizen of What Country? United States													
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White												
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 Years College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager				16b. Kind of Business/Industry Catering											
	17. Father's Name (First, Middle, Last) John S. Tighe					18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Rabe														
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Husband Mr. Joseph J. Hollis, Jr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1950 Guy Way Dundalk, Maryland 21222															
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Ht. of Jesus Cem.		Date 8/8/96		20c. Location - City or Town, State Dundalk, Maryland													
	21. Signature of Funeral Service licensee 				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222															
	23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
	<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. BRAIN HERNIATION</td> <td>Due to (or as a consequence of):</td> <td rowspan="4">One day</td> </tr> <tr> <td>b. MASSIVE CEREBRAL HEMORRHAGE</td> <td>Due to (or as a consequence of):</td> <td rowspan="3">Four Days</td> </tr> <tr> <td>c. _____</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____</td> <td>Due to (or as a consequence of):</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a. BRAIN HERNIATION	Due to (or as a consequence of):	One day	b. MASSIVE CEREBRAL HEMORRHAGE	Due to (or as a consequence of):	Four Days	c. _____	Due to (or as a consequence of):	d. _____
Immediate Cause (Final disease or condition resulting in death)	a. BRAIN HERNIATION	Due to (or as a consequence of):	One day																	
	b. MASSIVE CEREBRAL HEMORRHAGE	Due to (or as a consequence of):		Four Days																
	c. _____	Due to (or as a consequence of):																		
	d. _____	Due to (or as a consequence of):																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown												
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred												
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)														
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																				
29b. Signature and title of certifier RESIDENT				29c. License number A22441614-16			29d. Date signed (Month, Day, Year) AUGUST 4th 1996													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K. AMBALAVANAR, HARBOR HOSPITAL CENTER, SOUTH HANOVER STREET.																				
31. Date filed (Month, Day, Year) AUG 07 1996				32. Registrar's Signature 																

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23363

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FLOYD B. JOHNSON						2. Date of Death Month Aug Day 3 Year 1996		3. Time of Death 3:30 pm		
	4a. Facility Name (If not institution, give street and number) Bayview Hospital						4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 2705-737		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 10/18/07		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 5009 Frankford Avenue				10f. Zip Code 21206		10g. Citizen of What Country? United States					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sexton				16b. Kind of Business/Industry Church			
17. Father's Name (First, Middle, Last) XCharles Johnson						18. Mother's Name (First, Middle, Maiden Surname) Ella Combs					
19a. Informant's Name/Relationship (Type, Print) Abry Johnson						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2302 E. Coldspring Lane, Baltimore, MD 21214					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Mem. Gardens			Date 8-7-96		20c. Location - City or Town, State Baltimore, MD			
21. Signature of Funeral Service Licensee James Combs						22. Name and Address of Facility March Funeral Home 1101 E. North Avenue, Baltimore, Maryland 21202					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last PROSTATE CA, DISSENTIA, PUD, ANEMIA Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PROSTATE CA, DISSENTIA, PUD, ANEMIA										Approximate Interval Between Onset and Death HOURS	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier M.D.		29c. License number 041291		29d. Date signed (Month, Day, Year) 8/6/96				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Combs, MD, 21202 N. 2nd St, Baltimore, MD 21202											
31. Date filed (Month, Day, Year) AUG 07 1996			32. Registrar's Signature Davidson-Randall								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23364

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary

H.

Kinsley

2. Date of Death

August

Day

5

Year

1996

3. Time of Death

5:00 A.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

500 Seminole Avenue

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

219-40-9033

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

8. Data of Birth

Nov. 17, 1913

9. Birthplace (State or Foreign Country)

Baltimore

Usual Residence of Decedent

10a. State

Md.

10b. County

Howard

10c. City, Town or Location

Woodbine

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15813 Bellis Drive

10f. Zip Code

21797

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

Thomas C. DePriest

18. Mother's Name (First, Middle, Maiden Surname)

Nora E. Calhoun

19a. Informant's Name/Relationship (Type, Print)

Carole Garrett (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

500 Seminole Avenue Catonsville, Maryland 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

August 8, 1996
Woodlawn Cemetery

20c. Location - City or Town, State

Woodlawn, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Witzke Funeral Home, Inc.

1630 Edmondson Avenue Catonsville, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cardiopulmonary arrest

Due to (or as a consequence of):

Pancreatic cancer

Due to (or as a consequence of):

Diabetes mellitus

Due to (or as a consequence of):

Hypertension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Senile dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

820339

29d. Date signed (Month, Day, Year)

8/6/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

19 Walker Ave Suite 203 Baltimore MD 21208

31. Date filed (Month, Day, Year)

AUG 07 1996

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23365

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mabel Calder Klair				2. Date of Death Month Aug. Day 3 Year 1996				3. Time of Death 11:45 AM	
	4a. Facility Name (If not institution, give street and number) Pickersgill Retirement Community				4b. City, Town, or Location of Death Towson				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216-09-1746		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) March 19 1906		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent 10a. State MD 10b. County Baltimore 10c. City, Town or Location Towson 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 615 Chestnut Avenue		10f. Zip Code 21204		10g. Citizen of What Country? USA	
To Be Completed by Funeral Director	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary				16b. Kind of Business/Industry Legal			
	17. Father's Name (First, Middle, Last) John Calder				18. Mother's Name (First, Middle, Maiden Surname) Unknown by informant					
	19e. Informant's Name/Relationship (Type, Print) James G. Klair				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Killala Ct., Timonium, MD 21093					
Physician /Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date Aug. 5, 1996		20c. Location - City or Town, State Catonsville, MD			
	21. Signature of Funeral Service Licensee Lowell M. Lemmon				22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093					
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. DIABETES MELLITUS Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. c. d. Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death 2 yr	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPER TENSION COLON CANCER								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
To the Hospital or Attending Physician: This form requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier Barbara Carroll MD				29c. License number D38392				29d. Date signed (Month, Day, Year) 8/5/96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BARBARA CARROLL MD 13801 YORK RD., COCKEYSVILLE, MD 21030									
31. Date filed (Month, Day, Year) AUG 07 1996										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM J. LUECKEL				2. Date of Death Month Day Year JULY 21, 1996				3. Time of Death 23:28	
	4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL 4703 Ridgeway Avenue				4b. City, Town, or Location of Death BALTIMORE COUNTY				4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 060-09-2659		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 79		8. Date of Birth (Month, Day, Year) DECEMBER 10, 1916		9. Birthplace (State or Foreign Country) BRONX, NEW YORK	
	Usual Residence of Decedent				10a. State MARYLAND				10b. County BALTIMORE	
To Be Completed by Funeral Director	10c. City, Town or Location BALTIMORE COUNTY				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	10e. Street and Number 4703 RIDGEWAY AVENUE				10f. Zip Code 21206				10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BRONZE & MARBLE REFINISHER				16b. Kind of Business/Industry SELF-EMPLOYED	
	17. Father's Name (First, Middle, Last) WALTER LUECKEL				18. Mother's Name (First, Middle, Maiden Surname) TILLY BUMER					
	19a. Informant's Name/Relationship (Type, Print) ESTHER H. LUECKEL (WIFE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4703 RIDGEWAY AVENUE BALTIMORE, MARYLAND 21206					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY, INC. JULY 25, 1996				20c. Location - City or Town, State BALTIMORE, MARYLAND	
	21. Signature of Funeral Service Licensee <i>Booth</i>				22. Name and Address of Facility LASSAHN FUNERAL HOME, INC. 7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Cardiac arrest</i> Due to (or as a consequence of): b. <i>pulmonary fibrosis</i> Due to (or as a consequence of): c. <i>Diabetes Mellitus</i> Due to (or as a consequence of): d. <i></i>								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>M. Cawaller</i>				29c. License number D28177		
				29d. Date signed (Month, Day, Year) 7/22/96						
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARY CARROLL 4801 BELAIR RD BALTO MD 21206				31. Date filed (Month, Day, Year) AUG 07 1996				32. Registrar's Signature <i>Davidson-Randall</i>		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23367

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HELEN LOUISE LEE				2. Date of Death Month Aug Day 05 Year 96				3. Time of Death 1310 Hrs.	
	4a. Facility Name (If not institution, give street and number) St. Agnes Hospital				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A	
Funeral Director	5. Social Security Number 212-03-6503		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) May 1, 1913		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Md.		10b. County Baltimore		10c. City, Town or Location Catonsville				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 426 Overbrook Road				10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) _____			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Telephone Operator			16b. Kind of Business/Industry Telephone Company			
	17. Father's Name (First, Middle, Last) Harry Martin Brown				18. Mother's Name (First, Middle, Maiden Surname) Frances Mansfield					
	19a. Informant's Name/Relationship (Type, Print) Richard W. Lee (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 426 Overbrook Road Catonsville, Maryland 21228					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory			20c. Date August 9, 1996		20d. Location - City or Town, State Beltsville, Maryland		
	21. Signature of Funeral Service Licensee Juanita R. Thomas				22. Name and Address of Facility Witzke Funeral Home, Inc. 1630 Edmondson Avenue Catonsville, Maryland					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): a. CELLULITIS OF BOTH LOWER EXTREMITIES 2 MONTHS b. PERIPHERAL VASCULAR DISEASE 4 YEARS c. _____ d. _____ Approximate Interval Between Onset and Death 3 DAYS									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
State Registrar	29b. Signature and title of certifier F. Ansa				29c. License number PO 9519		29d. Date signed (Month, Day, Year) AUG 05 1996			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS ANSAH, MD 900 CATON AVE. ST AGNES HOSPITAL, BALTIMORE, MD 21229									
31. Date filed (Month, Day, Year) AUG 07 1996		32. Registrar's Signature Juanita R. Thomas								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23368

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Betty Lynette Lewetzki

2. Date of Death

Month Day Year
August 2, 1996

3. Time of Death

11:08 AM

4a. Facility Name (If not institution, give street and number)

Ivy Hall Geriatric Center

4b. City, Town, or Location of Death

Middle River

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

215-28-6252

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 20, 1921

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

981 Dalton Avenue

10f. Zip Code

21224

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Herbert McClellan

18. Mother's Name (First, Middle, Maiden Surname)

Anna Ross

19a. Informant's Name/Relationship (Type, Print)

Doreen M. Couman Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21 Softwinds Court Owings Mills, Maryland 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

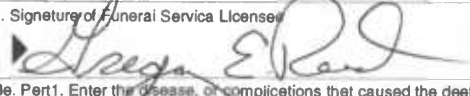
Meadowridge Mem. Pk. 8/5/ 1996

Date

20c. Location - City or Town, State

Dorsey, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Avenue Baltimore, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CARCINOMA OF LUNGS

Approximate interval Between Onset and Death

6 months

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPOTHYROIDISM

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D. 17728

29d. Date signed (Month, Day, Year)

8-5-96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

BA YIN OUNG, M.D. 8932 BELAIR ROAD, BALTIMORE md. 21236

31. Date filed (Month, Day, Year)

AUG 07 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

to the hospital or attending physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23369

ITEM#8 g738 8/9/96ag perFH

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James R Morris						2. Date of Death Month 8 Day 4 Year 96		3. Time of Death 4 AM	
	4a. Facility Name (If not Institution, give street and number) Baltimore VA MC						4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 217-26-5080		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) JAN 2, 1924		9. Birthplace (State or Foreign Country) CHIPLEY, GA	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County n/a		10c. City, Town or Location BALTIMORE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 1935 W. NORTH AVENUE				10f. Zip Code 21217		10g. Citizen of What Country? UNITED STATES			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 10-42/12-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: XX		14. Race - American Indian, Black, White, etc. Specify: BLACK			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) - College (1-4 or 5+) 4 years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ELECTRICIAN		16b. Kind of Business/Industry ELECTRICAL CO.			
	17. Father's Name (First, Middle, Last) JAMES MORRIS						18. Mother's Name (First, Middle, Maiden Summa) ALTA COPELAND			
	19a. Informant's Name/Relationship (Type, Print) HOWARD BROOKS				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3604 THE ALAMEDA, BALTIMORE, MD 21218					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FORST VA CEM. 8-8		Date		20c. Location - City or Town, State OWINGS MILLS, MD			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility WM. C. MARCH FH.-1101 E. NORTH AVENUE					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ruptured Abdominal Aortic Aneurysm Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Perforated duodenal ulcer s/p repair Jehovah's W. men									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>T Chin MD</i>		29c. License number 06120		29d. Date signed (Month, Day, Year) 8/4/96				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T CHIN Surgical Resident BVAMC, BALTIMORE, MARYLAND										
31. Date filed (Month, Day, Year) AUG 07 1996		32. Registrar's Signature <i>[Signature]</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT J. MOSLEY				2. Date of Death Month Day Year AUGUST 3 1996		3. Time of Death 5:50P.M.		
	4a. Facility Name (If not institution, give street and number) 5302 BOWLEYS LANE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death n/a		
Funeral Director	5. Social Security Number 216-36-3247	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUL. 24, 1941		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD	10b. County n/a	10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 5302 BOWLEYS LANE			10f. Zip Code apt.L 21206		10g. Citizen of What Country? UNITED STATES			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 th College (1-4 or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LONGSHOREMAN			16b. Kind of Business/Industry STEAM SHIP TRADE			
	17. Father's Name (First, Middle, Last) WILLIAM C. MOSLEY				18. Mother's Name (First, Middle, Maiden Surname) ANNA MAE WILLIAMS				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) HARRIETT H. MOSLEY -sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1022 ASHLAND AVENUE, BALTIMORE, MD 21202				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE CEMETERY		20c. Location - City or Town, State 8-9-96 BALTIMORE, MARYLAND				
	21. Signature of Funeral Service Licensee <i>Patricia M. Davis</i>				22. Name and Address of Facility WM. C. MARCHFH.-1101 E. NORTH AVENUE				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hypertensive Arteriosclerotic Cardiovascular Disease								
	23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hypertensive Arteriosclerotic Cardiovascular Disease								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? INSPECTION <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier <i>Donald G. Wright MD</i>				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) AUGUST 4, 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) AUG 07 1996			32. Registrar's Signature <i>Julia Davidson-Randall</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

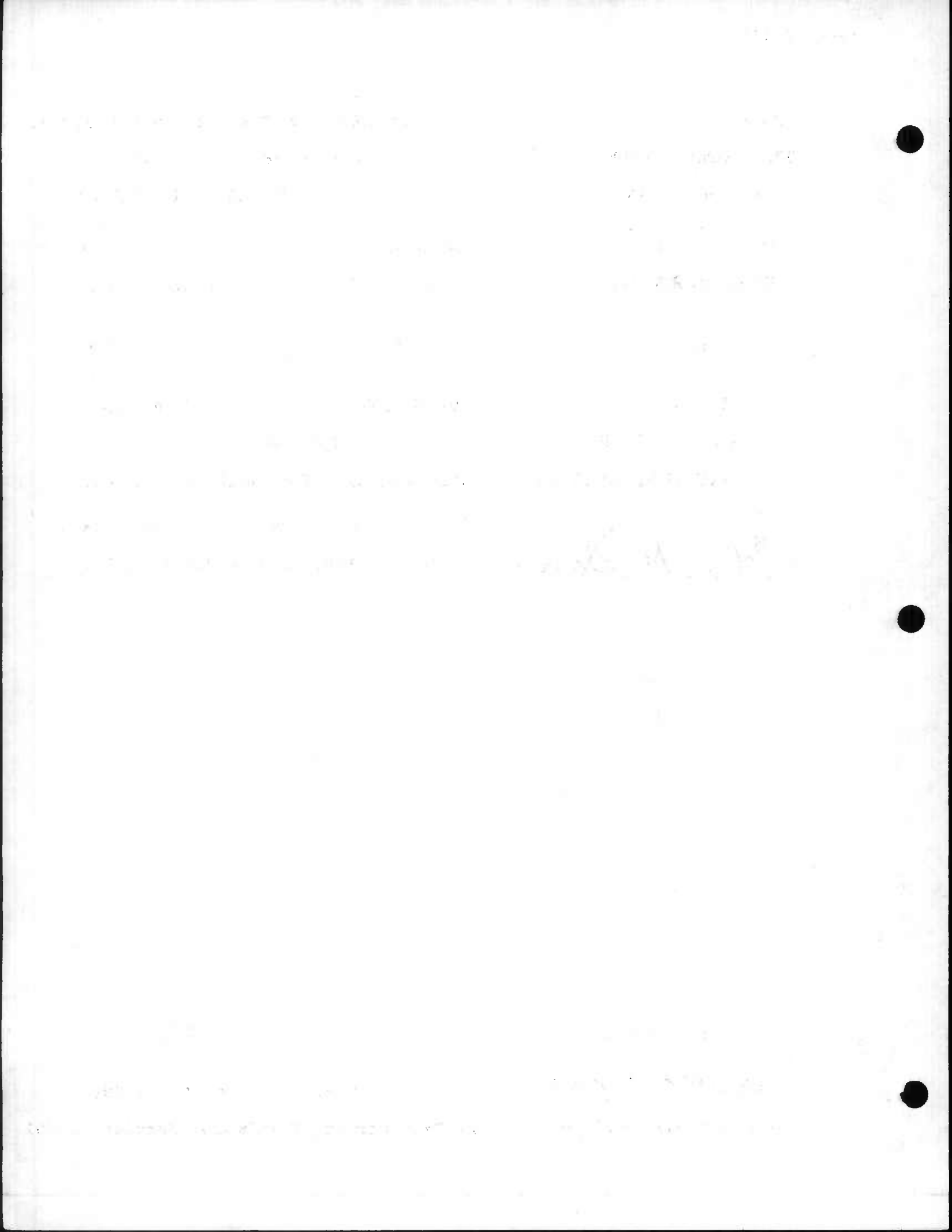
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

is the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To be signed by the attending physician and the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit certificate filed in by the funeral director.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DOMINICK M. MILANDO		2. Date of Death Month AUGUST Day 3 Year 1996		3. Time of Death 9:32 P.M.
	4a. Facility Name (If not institution, give street and number) ST. AGNES HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death n/a
Funeral Director	5. Social Security Number 220-12-9927	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Dec. 5, 1925		9. Birthplace (State or Foreign Country) Italy		
To Be Completed by Funeral Director	10a. State Md.		10b. County n/a		10c. City, Town or Location Baltimore
	10e. Street and Number 2239 Wilkins Ave.		10f. Zip Code 21223		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) Technician		
To Be Completed by Physician/Medical Examiner	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Telephone Company		17. Kind of Business/Industry Telephone Company		
	17. Father's Name (First, Middle, Last) Michael Milando		18. Mother's Name (First, Middle, Maiden Surname) Anna DiVilo		
	19a. Informant's Name/Relationship (Type, Print) Mary Milando		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2239 Wilkins Ave. Baltimore Md. 21223		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park		20c. Location - City or Town, State Baltimore Md.
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Marzullo Funeral Service 3981 Carrollton Road Upperco Md. 21155		
	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Arteriosclerotic Cardiovascular Disease		Approximate Interval Between Onset and Death		
	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? INSPECTION		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) M 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how Injury occurred 111 Penn Street, Baltimore, Maryland 21201		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier O.C.M.E. 29c. License number AUGUST 4, 1996 29d. Date signed (Month, Day, Year)		
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DONALD G. WRIGHT MD		31. Date filed (Month, Day, Year) AUG 07 1996		
	32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23372

Item 4c, Film 738, 8/7/96, 1t

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Wanda Metcalf				2. Date of Death Month August Day 2 Year 1996		3. Time of Death 3:53 PM	
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore N/A	
Funeral Director	5. Social Security Number 219-38-0854		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 54 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 2, 1941	
	9. Birthplace (State or Foreign Country) Kentucky		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 7818 East Collingham Drive Apt. B		10f. Zip Code 21222		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Toll Collector		16b. Kind of Business/Industry State Government		17. Father's Name (First, Middle, Last) Franklin E. Adams	
	18. Mother's Name (First, Middle, Maiden Surname) Hazel Victoria Daniels		19a. Informant's Name/Relationship (Type, Print) Sylvan Metcalf Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7818 East Collingham Drive Apt B Balto, Md. 21222		20. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Baltimore, Maryland 21222		23a. Pert 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ventricular tachycardia Due to (or as a consequence of): previous myocardial infarction Due to (or as a consequence of): COPD, depression		Approximate Interval Between Onset and Death 24 hours 9 years	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Fred Hsieh MD		29c. License number N3195		29d. Date signed (Month, Day, Year) August 2, 1996	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fred Hsieh, MD Johns Hopkins Bayview Medical Center		31. Date filed (Month, Day, Year) AUG 07 1996		32. Registrar's Signature 		33. Registrar's Title Registrar	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23373

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Karen D. Martin				2. Date of Death Month August Day 02 Year 96				3. Time of Death 4:10 P	
	4a. Facility Name (If not institution, give street and number) LIBERTY MEDICAL CENTER				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 220-805762		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 37 Yrs.		8. Date of Birth (Month, Day, Year) NOV. 24, 1958		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent									
10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE CITY				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 813 DUMBARTON AVENUE				10f. Zip Code 21218		10g. Citizen of What Country? USA				
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK			
15. Decedent's Education (Specify only highest grade completed) 9TH GRADE				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEKEEPER				16b. Kind of Business/Industry HOTEL		
17. Father's Name (First, Middle, Last) FRED MARTIN				18. Mother's Name (First, Middle, Maiden Surname) HELEN PARTLOW						
19a. Informant's Name/Relationship (Type, Print) HELEN PARTLOW				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 186 W. HAMBURG ST., BALTO, MD. 21230						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) ARBUTUS CEMETERY		20c. Location - City or Town, State 8-7-96 ARBUTUS, MARYLAND				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 2140 N. FULTON AVE., BALTIMORE, MD. 21217						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Bilateral pneumonia Due to (or as a consequence of): b. SEPSIS Due to (or as a consequence of): c. Adult Immunodeficiency Syndrome Due to (or as a consequence of): d. Cardio-pulmonary arrest										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 				29c. License number D30115		29d. Date signed (Month, Day, Year) 8/2/96				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T. Ohiokepehain 22200 Liberty HERS AVE BRIT, MD 21215										
31. Date filed (Month, Day, Year) AUG 07 1996				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23374

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Eileen H Noble</i>					2. Date of Death Month <i>8</i> Day <i>5</i> Year <i>96</i>		3. Time of Death <i>9:45 pm</i>	
	4a. Facility Name (If not institution, give street and number) <i>CHARLESTOWN CARE CENTER</i>					4b. City, Town, or Location of Death <i>CATONSVILLE</i>		4c. County of Death <i>Baltimore City</i>	
Funeral Director	5. Social Security Number <i>212 05 1318</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>90</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>5/22/06</i>		9. Birthplace (State or Foreign Country)
	Usual Residence of Decedent								
10a. State <i>Md.</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Catonville</i>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <i>715 Maiden Choice Lane</i>				10f. Zip Code <i>21228</i>		10g. Citizen of What Country? <i>U.S.A.</i>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> Collega (1-4or 5+) <i>-</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Telephone Operator</i>			16b. Kind of Business/Industry <i>Telephone Co. C. & P.</i>		
17. Father's Name (First, Middle, Last) <i>William T. Ackman</i>					18. Mother's Name (First, Middle, Maiden Sumame) <i>Elizabeth Clifford</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Dorothy Leonard</i>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>123 Elsmere Ave. Delmar, N.Y. 12054</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Evergreen Mem. Gardens</i>			20c. Location - City or Town, State <i>Finksburg, Md.</i>		20d. Date <i>8/9/06</i>	
21. Signature of Funeral Service Licensee <i>Harry W. Haight</i>					22. Name and Address of Facility <i>Haight Funeral Home P.O. Box 195 Sykesville, Md. 21784</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <i>Congestive heart failure</i> Due to (or as a consequence of): b. <i>Complete heart block</i> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dementia</i> <i>Lymphoma</i>									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <i>Myra M Carpenter MD</i>			29c. License number <i>D 30989</i>		29d. Date signed (Month, Day, Year) <i>08/06/96</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Myra M Carpenter MD</i>									
31. Date filed (Month, Day, Year) <i>AUG 07 1996</i>									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23375

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JACQUELINE PLAYER

2. Date of Death

Aug 05 1996

3. Time of Death

05:55 A

4a. Facility Name (If not institution, give street and number)

NORTHWEST MEDICAL CENTER

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

MD

Funeral
Director

5. Social Security Number

219-66-7473

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

39 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
AUG. 11, 1956

9. Birthplace (State or Foreign Country)

BALTIMORE, MD

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3900 ESSEX ROAD

10f. Zip Code

@ 21244

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

XX Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
if Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10 th

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

HOUSEKEEPER

16b. Kind of Business/Industry

ARA SERVICES

17. Father's Name (First, Middle, Last)

CHARLIE PLAYER

18. Mother's Name (First, Middle, Maiden Surname)

ANNIE M. GRAHAM

19a. Informant's Name/Relationship (Type, Print)

ANNIE MAE PLAYER-mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3501 LYNNE HAVEN DRIVE, BALTIMORE, MD 21244

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE CEMETERY 8+9-96

Date

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

Dolores M. Davis

22. Name and Address of Facility

WM. C. MARCHFH.-1101 E. NORTH AVENUE

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. HEPATIC FAILURE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

S. J. Davidson

29c. License number

D40491

29d. Date signed (Month, Day, Year)

Aug. 05. 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Syed A. Ali 801 N. Hammond's Ferry Rd. Lutherville 21090

31. Date filed (Month, Day, Year)

AUG 07 1996

32. Registrar's Signature

S. J. Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

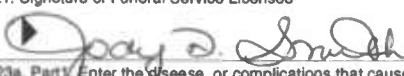
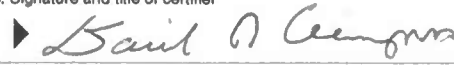
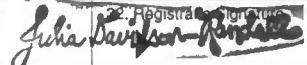
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23376

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HELENA E PFEFFER			2. Date of Death Month Day Year AUGUST 4, 1996			3. Time of Death 4:31am			
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL			4b. City, Town, or Location of Death BALTIMORE CITY			4c. County of Death N/A			
Funeral Director	5. Social Security Number 220-16-5346			6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) 03-28-26		
	9. Birthplace (State or Foreign Country) Maryland			10a. State Md			10b. County n/a			
To Be Completed by Funeral Director	Usual Residence of Decedent			10c. City, Town or Location Baltimore, Maryland			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 1806 Woodburne Avenue			10f. Zip Code 21239			10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			
	14. Race - American Indian, Black, White, etc. Specify: White			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teller			
	16b. Kind of Business/Industry Banking			17. Father's Name (First, Middle, Last) Henry Trossbach			18. Mother's Name (First, Middle, Maiden Surname) Alice McKay			
	19a. Informant's Name/Relationship (Type, Print) Clifford B Pfeffer			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Independence Dr., New Freedom, Pa. 17349						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Memorial Cemet. 8-8-96			20c. Location - City or Town, State Baltimore Co. Md.			
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Hartley Miller Funeral Home 7527 Harford Rd. Baltimore, Md 21234						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. metabolic Acidosis Due to (or as a consequence of): b. Acute renal failure Due to (or as a consequence of): c. Acute myelocytic Leukemia Due to (or as a consequence of): d.									
	Approximate Interval Between Onset and Death 24 hours 1 week 1 month									
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypernatremia Aspergillus sinusitis						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)			28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred			28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier 			29c. License number D47550			29d. Date signed (Month, Day, Year) August 4, 1996			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID L. J. George 126 Medical Oncology JHK 600 N Wolfe St Baltimore, MD 21287									
State Registrar	31. Date filed (Month, Day, Year) AUG 07 1996			32. Registrar's Signature 						

96 23377

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Marilyn Lou Pokrywka				2. DATE OF DEATH MONTH DAY YEAR August 2, 1996		3. TIME OF DEATH 3:00 P. M.	
4. SOCIAL SECURITY NUMBER 213-26-6590		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 65 YRS.	7. DATE OF BIRTH (Month, Day, Year) 2-17-1931		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not Institution, give street and number) 2614 Burrigade Road				9b. CITY, TOWN OR LOCATION OF DEATH Parkville		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Parkville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2614 Burrigade Road				10f. ZIP CODE 21234		10g. CITIZEN OF WHAT COUNTRY? U. S. A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5 +)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Louis Valentine				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Keener			
19a. INFORMANT'S NAME (Type/Print) Richard A. Pokrywka (Husband)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2614 Burrigade Road, Parkville, Maryland 21234			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery Maus. 8-5-96		20c. LOCATION — City or Town, State Parkville, Maryland		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Wallace S. Brooks, Jr.				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Diffuse large cell lymphoma							
Due TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Paul Chang, M.D.				29c. LICENSE NUMBER D16587		29d. DATE SIGNED (Month, Day, Year) 8/3/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Chang, M.D. 5601 Loch Raven Blvd., Baltimore, Maryland 21239							
31. DATE FILED (Month, Day, Year) AUG 07 1996				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23378

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MERLE L. RIPLEY						2. Date of Death Month AUGUST , Day 6 , Year 1996		3. Time of Death 10:05 AM			
	4a. Facility Name (If not institution, give street and number) Brooke Grove Rehabilitation Center						4b. City, Town, or Location of Death Sandy Spring		4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 216-58-5932		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 9, 1905		9. Birthplace (State or Foreign Country) New York			
	Usual Residence of Decedent						10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						10e. Street and Number 1217 Harding Lane		10f. Zip Code 20905		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own home							
	17. Father's Name (First, Middle, Last) John E. Leathem						18. Mother's Name (First, Middle, Maiden Surname) Grace Stringham					
	19a. Informant's Name/Relationship (Type, Print) Susan Johnson/Daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1217 Harding Lane, Silver Spring, Maryland 20905					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore-Washington Cr.		20c. Date 8/7/96		20d. Location - City or Town, State Laurel, Maryland					
	21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. DEHYDRATION Due to (or as a consequence of):</p> <p>b. DYSPHAGIA Due to (or as a consequence of):</p> <p>c. CEREBRAL INFARCT Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p>2 WEEKS</p> </div> </div>											
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D33700		29d. Date signed (Month, Day, Year) AUGUST 6, 1996						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TED E. HOWE 7542 OVERLOOK DR. ROCKFORD, MD 21713												
31. Date filed (Month, Day, Year) AUG 07 1996												

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23379

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Amy V. Riehl				2. Date of Death Month August Day 4 Year 1996		3. Time of Death 7:58 PM										
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore										
Funeral Director	5. Social Security Number 215-64-8602		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 02/06/1914	9. Birthplace (State or Foreign Country) Maryland									
	Usual Residence of Decedent																
To Be Completed by Funeral Director	10a. State MD.		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
	10e. Street and Number 7053 E. Baltimore St.				10f. Zip Code 21224		10g. Citizen of What Country? U.S.A.										
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Own Home										
	17. Father's Name (First, Middle, Last) Edward Perkna				18. Mother's Name (First, Middle, Maiden Surname) Mabel Slaughter												
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Virginia Wilson/ Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7053 E. Baltimore St. Baltimore, MD. 21224												
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		Date 8/8/96		20c. Location - City or Town, State Baltimore, MD.										
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Moran-Ashton Funeral Home, Inc. 21224 3000 E. Baltimore St., Baltimore, MD.												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
	<table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Hypoxemia Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death 4 hours</td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. Pneumonia Due to (or as a consequence of):</td> <td>3 days</td> </tr> <tr> <td>c. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of):</td> <td>20 years</td> </tr> <tr> <td>d. Cigarette Smoking Due to (or as a consequence of):</td> <td>40 years</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Hypoxemia Due to (or as a consequence of):	Approximate Interval Between Onset and Death 4 hours	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Pneumonia Due to (or as a consequence of):	3 days	c. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of):	20 years	d. Cigarette Smoking Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. Hypoxemia Due to (or as a consequence of):	Approximate Interval Between Onset and Death 4 hours															
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Pneumonia Due to (or as a consequence of):	3 days															
	c. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of):	20 years															
	d. Cigarette Smoking Due to (or as a consequence of):	40 years															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease Hypertension						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred													
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  MD		29c. License number N2624		29d. Date signed (Month, Day, Year) August 4, 1996											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benjamin H. Trichon, MD Johns Hopkins Hospital Baltimore, MD 21287																	
31. Date filed (Month, Day, Year) AUG 07 1996		32. Registrar's Signature 															

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

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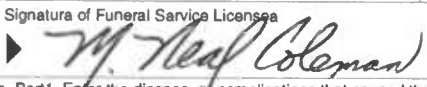
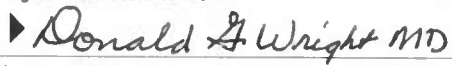
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 23380

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LARRY DONALD RINGROSE		2. Date of Death Month AUGUST Day 02 , Year 1996		3. Time of Death 1225PM
	4a. Facility Name (If not institution, give street and number) HOWARD COUNTY GENERAL HOSPITAL		4b. City, Town, or Location of Death COLUMBIA		4c. County of Death HOWARD COUNTY
Funeral Director	5. Social Security Number 219-62-0519	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 40 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Dec. 19, 1955		9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Ferndale		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 228 Olen Drive Apartment A		10f. Zip Code 21060		10g. Citizen of What Country? U. S. A.
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Handyman
	17. Father's Name (First, Middle, Last) Melvin RINGROSE		18. Mother's Name (First, Middle, Maiden Surname) Daisy NEWSOME		
	19a. Informant's Name/Relationship (Type, Print) Betty L. Collins - Sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1016 Roseanne Road Glen Burnie, MD 21060		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park		20c. Location - City or Town, State 8/6/96 Glen Burnie, MD
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, MD 21229		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. HANGING Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day, Year) 7-31-96					
28b. Time of Injury 0805 M					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred SUBJECT HANGED SELF					
28f. Location (Street and Number or Rural Route Number, City or Town, State) 7555 Waterbury Road JESSUP, HOWARD CO, MD					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 					
29c. License number O.C.M.E.					
29d. Date signed (Month, Day, Year) AUGUST 03, 1996					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DONALD G WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) AUG 07 1996					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. The first part of the report is a general introduction to the subject.

2. The second part of the report is a detailed description of the methods used.

3. The third part of the report is a discussion of the results obtained.

4. The fourth part of the report is a conclusion and summary of the work.

5. The fifth part of the report is a list of references.

6. The sixth part of the report is a list of figures.

7. The seventh part of the report is a list of tables.

8. The eighth part of the report is a list of appendices.

9. The ninth part of the report is a list of footnotes.

10. The tenth part of the report is a list of acknowledgments.

11. The eleventh part of the report is a list of references.

1980.7.5.2010

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23381

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) FRANCES RUTH ROUZER				2. Date of Death Month JULY Day 30 Year 1996		3. Time of Death 9.45 PM	
4a. Facility Name (If not institution, give street and number) UNION MEMORIAL HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE	
5. Social Security Number 216-20-0715		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JULY 3, 1908	
9. Birthplace (State or Foreign Country) MARYLAND							
10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE CITY			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 700 EAST 41ST STREET				10f. Zip Code 21218		10g. Citizen of What Country? USA.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) 6TH GRADE				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEKEEPER		16b. Kind of Business/Industry PRIVATE HOMES	
17. Father's Name (First, Middle, Last) IKE MORRIS				18. Mother's Name (First, Middle, Maiden Surname) LOTTIE DUNSON			
19a. Informant's Name/Relationship (Type, Print) ELVA HALEY				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 EAST 41ST STREET, BALTIMORE, MD. 21218			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) VOSHALL MEM. GARDENS		20c. Location - City or Town, State 8-5-96 BALTIMORE, MARYLAND			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 2140 N. FULTON AVE, BALTIMORE, MD. 21217			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION HOURS Due to (or as a consequence of): b. ANGINA YEARS Due to (or as a consequence of): c. ANEMIA YEARS Due to (or as a consequence of): d. HYPERTROPHIC CARDIOMYOPATHY YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D45921		29d. Date signed (Month, Day, Year) 8-01-96	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SYED F. MAHMOOD MD. UNION MEMORIAL HOSPITAL BALTIMORE MD 21201							
31. Date filed (Month, Day, Year) AUG 07 1996							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

3

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23382

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Fillmore Carl Reddinger, Sr.

2. Date of Death
Month Day Year

August 4, 1996

3. Time of Death
4:30 PM

4a. Facility Name (If not institution, give street and number)

1123 Steiger Way

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

190-18-2547

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 4, 1924

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1123 Steiger Way

10f. Zip Code

21205

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired)

Stockman

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

William J. D. Reddinger

18. Mother's Name (First, Middle, Maiden Surname)

Anna Elizabeth Young

19a. Informant's Name/Relationship (Type, Print)

Mrs. Ruth J. Reddinger/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1123 Steiger Way Baltimore, Maryland 21205

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Holly Hill Mem. Gdns 8/7/1996

Date

20c. Location - City or Town, State

Middle River, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Brain Tumor, Glioma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Not

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D09350

29d. Date signed (Month, Day, Year)

8/5/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

R. S. Mingo

7811 Wise Ave. Dundalk, Maryland 21222

State
Registrar

31. Date filed (Month, Day, Year)

AUG 07 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23383

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thomas Rauh				2. Date of Death Month August Day 2 Year 1996		3. Time of Death 6:03 PM		
	4a. Facility Name (If not institution, give street and number) University of Maryland Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 218-48-1978		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 10, 1948		
	9. Birthplace (State or Foreign Country) Maryland								
To Be Completed by Funeral Director	10a. State Md.		10b. County Baltimore		10c. City, Town or Location Baltimore			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 8402 Allison Lane				10f. Zip Code 21237		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Painter		16b. Kind of Business/Industry Park Raven Apartments				
	17. Father's Name (First, Middle, Last) Sebastian M. Rauh				18. Mother's Name (First, Middle, Maiden Surname) Margaret Franke				
	19a. Informant's Name/Relationship (Type, Print) Lois Rauh/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8402 Allison Lane, Baltimore, Md. 21237				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Cemetery		Date 8/6/96		20c. Location - City or Town, State Baltimore, Md.		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility 2818 E. Baltimore St. 21224 Bernard Dabrowski & Son Funeral Home				
	23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) e. Ruptured Intracranial Aneurysm Due to (or as a consequence of):								2 Hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier  Neurosurgery				29c. License number 06614		29d. Date signed (Month, Day, Year) 8/2/96			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) P. Doherty, 22 S. Greene St, Baltimore, MD 21209									
31. Date filed (Month, Day, Year) AUG 07 1996				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

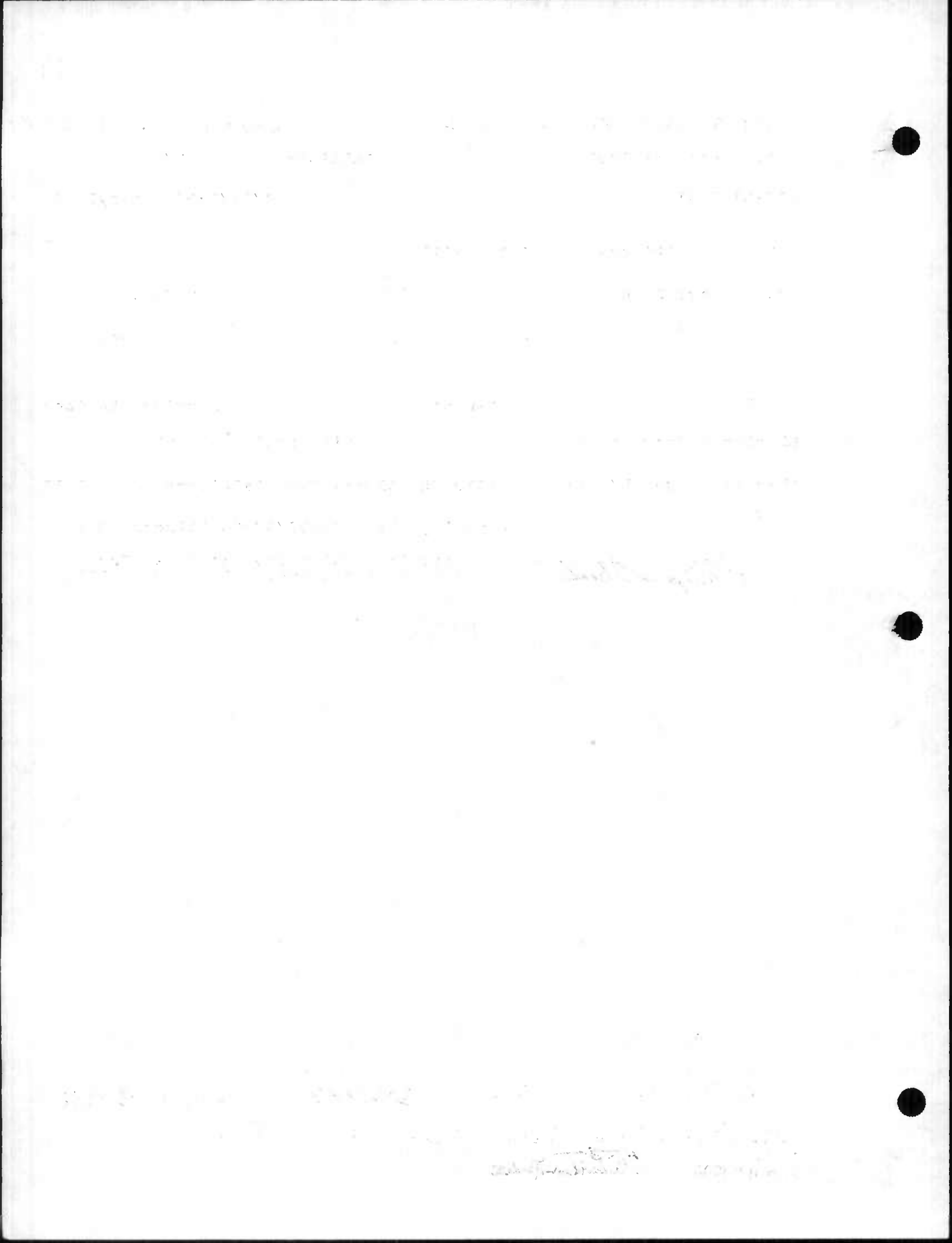
96 23384

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES A. SHAAAB				2. Date of Death Month Day Year AUGUST 03 96		3. Time of Death 17:55 PM		
	4a. Facility Name (If not institution, give street and number) St. Agnes Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 216-01-7231		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) 08/11/1908		
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD.		10b. County Baltimore		10c. City, Town or Location Catonsville		
Usual Residence of Decedent		10d. Inside City Limits 1 Yes 2 No		10e. Street and Number 104 Nunnery Lane		10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager		16b. Kind of Business/Industry Service Stations					
17. Father's Name (First, Middle, Last) Charles Andrew Shaab				18. Mother's Name (First, Middle, Maiden Surname) Emily Regina Albert					
19a. Informant's Name/Relationship (Type, Print) Charles T. Shaab/ Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5610 St. Albans Way Baltimore, MD. 21212					
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park		20c. Location - City or Town, State Baltimore, MD.					
21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility Sterling Ashton Funeral Home, Inc. 736 Edmondson Ave. Balto., MD. 21228							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): b. COMA Due to (or as a consequence of): c. SEIZURES Due to (or as a consequence of): d. HYPERTENSION						Approximate Interval Between Onset and Death DAYS DAYS DAYS YEARS			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
						24a. Was an autopsy performed? 1 Yes 2 No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier A. Janicki M.D.		29c. License number D47014		29d. Date signed (Month, Day, Year) August 03, 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. JANECKI, Johns Hopkins Hospital		31. Date filed (Month, Day, Year) AUG 07 1996		32. Registrar's Signature [Signature]					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23385

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDWARD SANDERS				2. Date of Death Month Day Year August 6 1996		3. Time of Death 6:06 A.M.																
	4a. Facility Name (If not institution, give street and number) ST. AGNES HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A																
Funeral Director	5. Social Security Number 214-03-0186		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 30, 1917																
	9. Birthplace (State or Foreign Country) BALTO., MD		10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE																
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																		
	10e. Street and Number 1922 RAMSAY STREET				10f. Zip Code 21223		10g. Citizen of What Country? U.S.A.																
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE																
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER		16b. Kind of Business/Industry RED STAR EXPRESS																
	17. Father's Name (First, Middle, Last) EDWARD L. SANDERS				18. Mother's Name (First, Middle, Maiden Surname) EMMA HAUCK																		
	19a. Informant's Name/Relationship (Type, Print) EDWARD SANDERS (GRANDSON)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2827 GEORGETOWN ROAD - BALTIMORE, MD 21230																		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD VETERANS CEMETERY CROWNSVILLE		Date 8/9/96		20c. Location - City or Town, State CROWNSVILLE, MD																
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229																		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																						
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>MYOCARDIAL INFARCT</td> <td rowspan="4">Approximate Interval Between Onset and Death 3 Days</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>SEVERE CORONARY ARTERY DISEASE</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequitentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>c.</td> <td></td> <td rowspan="2"></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a.	MYOCARDIAL INFARCT	Approximate Interval Between Onset and Death 3 Days	Due to (or as a consequence of):		b.	SEVERE CORONARY ARTERY DISEASE	Due to (or as a consequence of):		Sequitentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c.			d.
Immediate Cause (Final disease or condition resulting in death)	a.	MYOCARDIAL INFARCT	Approximate Interval Between Onset and Death 3 Days																				
	Due to (or as a consequence of):																						
	b.	SEVERE CORONARY ARTERY DISEASE																					
	Due to (or as a consequence of):																						
Sequitentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c.																						
	d.																						
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																
	Small Bowel Infarct																						
	Metastatic Ampullary Carcinoma						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																
							24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
			28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																						
	29b. Signature and title of certifier 				29c. License number D41843		29d. Date signed (Month, Day, Year) August 6, 1996																
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ann E. Reed St. Agnes Hospital 900 Caton Avenue Baltimore, MD 21229																						
	31. Date filed (Month, Day, Year) AUG 07 1996		32. Registrar's Signature 																				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State
Registrar

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State of Maryland / Department of Health and Mental Hygiene 96 23386

ITEM#4c film g738 8/7/96ag perFH

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DOROTHY S STOCKDALE				2. Date of Death Month Day Year AUGUST 2, 1996		3. Time of Death 10:35am																														
	4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE																														
Funeral Director	5. Social Security Number 214-26-3593	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 29, 1910	9. Birthplace (State or Foreign Country) Maryland																														
	Usual Residence of Decedent																																				
To Be Completed by Funeral Director	10a. State MD	10b. County Baltimore	10c. City, Town or Location Towson			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																															
	10e. Street and Number 7001 N. Charles St.			10f. Zip Code 21204		10g. Citizen of What Country? USA																															
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White																														
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) n/a		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry Own Home																															
	17. Father's Name (First, Middle, Last) Milton Bond				18. Mother's Name (First, Middle, Maiden Surname) Lily Barnhart																																
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Roger B. Stocksdales, Jr.			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4100 N. Charles St., Suite 611, Balto., MD 21218																																	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens		20c. Location - City or Town, State Timonium, MD		20d. Date 8/5/96																														
	21. Signature of Funeral Service Licensee Victor Lengrand, Jr. Victor Lengrand			22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093																																	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																				
	<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td colspan="6">Acute Congestive Heart Failure</td> <td rowspan="4">Approximate Interval Between Onset and Death 2 weeks</td> </tr> <tr> <td>b.</td> <td colspan="6">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td colspan="6">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td colspan="6">Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a.	Acute Congestive Heart Failure						Approximate Interval Between Onset and Death 2 weeks	b.	Due to (or as a consequence of):						c.	Due to (or as a consequence of):						d.	Due to (or as a consequence of):				
Immediate Cause (Final disease or condition resulting in death)	a.	Acute Congestive Heart Failure						Approximate Interval Between Onset and Death 2 weeks																													
	b.	Due to (or as a consequence of):																																			
	c.	Due to (or as a consequence of):																																			
	d.	Due to (or as a consequence of):																																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Bilateral Pneumonia						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown																															
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																															
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																																			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred																													
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier A.H. Ghiladi, M.D.		29c. License number D-12849		29d. Date signed (Month, Day, Year) 8-3-96																															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A.H. GHILADI, M.D. 7600 OSLER DR. TOWSON, MD. 21204																																					
31. Date filed (Month, Day, Year) AUG 07 1996		32. Registrar's Signature Julia Davidson-Randall																																			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

96 23387

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Charlotte Rauch Siemon				2. DATE OF DEATH August 4 1996		3. TIME OF DEATH 3:00 P.M.	
4. SOCIAL SECURITY NUMBER 214-26-9470		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 14 1912	
9a. FACILITY NAME (If not institution, give street and number) 315 Chapelwood Lane				9b. CITY, TOWN OR LOCATION OF DEATH Timonium		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Timonium		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 315 Chapelwood Lane				10f. ZIP CODE 21093		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Instructor for handicapped Education		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Clarence Rauch				16. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Paduzy			
19a. INFORMANT'S NAME (Type/Print) Alfred H. Siemon, II				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 315 Chapelwood Lane, Timonium, MD 21093			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mausoleum 8/7/96		20c. LOCATION — City or Town, State Timonium, MD 21093			
21. SIGNATURE OF FUNERAL SERVICE LICENSER <i>Lowell M. Lemmon</i>		22. NAME AND ADDRESS OF FACILITY Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Respiratory Failure</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Enlarged Colon + Breast</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Broken Hip + Melioidosis</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles F. O'Donnell MD</i>		29c. LICENSE NUMBER D-09383		29d. DATE SIGNED (Month, Day, Year) 8/1/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles F. O'Donnell MD - 11126 Milet H. 11 Rd - Baltimore							
31. DATE FILED (Month, Day, Year) AUG 07 1996							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68766, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: Also this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical-examiner must be notified at once.

96 23388

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) TANYA MICHELLE STREET				2. DATE OF DEATH MONTH DAY YEAR July 31, 1996				3. TIME OF DEATH 1:35 A M			
4. SOCIAL SECURITY NUMBER 218-74-6964		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 27 YRS.		7. DATE OF BIRTH (Month, Day, Year) APRIL 22, 1969		8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) STELLA MARIS AT MERCY				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH BALTIMORE			
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE CITY				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 2202 E. FAYETTE STREET				10f. ZIP CODE 21231		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th GRADE		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) GUARD		16b. KIND OF BUSINESS/INDUSTRY NEWSPAPER COMPANY							
17. FATHER'S NAME (First, Middle, Last) ALBERT STREET				18. MOTHER'S NAME (First, Middle, Maiden Surname) TONYA VANESSA BROOKS							
19a. INFORMANT'S NAME (Type/Print) SHEILA BROOKS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2202 E. FAYETTE ST, BALTIMORE, MD. 21231									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT ZION CEMETERY 8-396 BALTIMORE, MARYLAND		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND		22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 2140 N. FULTON AVE., BALTIMORE, MD. 21217					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 2140 N. FULTON AVE., BALTIMORE, MD. 21217							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. ACQUIRED IMMUNODEFICIENCY SYNDROME DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death yrs.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Kendall Faulkner		29c. LICENSE NUMBER D25643		29d. DATE SIGNED (Month, Day, Year) 7/31/96			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD. TOWSON, MD 21204											
31. DATE FILED (Month, Day, Year) AUG 07 1996		32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM T. SAMPLE				2. Date of Death Month Day Year JULY 28, 1996		3. Time of Death 2048 PM	
	4a. Facility Name (If not Institution, give street and number) 201 NORTH BROADWAY STREET APT. 5-M				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 213-30-3850	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JAN. 26, 1936		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County BALTIMORE	10c. City, Town or Location BALTIMORE CITY			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 201 N. BROADWAY			10f. Zip Code 21231		10g. Citizen of What Country? USA.		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 8-22-68 If Yes, Give Year or Dates: 5-31-74		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 YRS. College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MANAGER		16b. Kind of Business/Industry RECREATION (MILITARY)			
	17. Father's Name (First, Middle, Last) WILLIAM T. SAMPLE SR.				18. Mother's Name (First, Middle, Maiden Surname) GERTRUDE GUMBY			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) TALAYA SAMPLE			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 800 BRADHURST ROAD, BALTIMORE, MD. 21212				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST CEME.		20c. Location - City or Town, State 8-5-96 OWINGS MILLS, MD.			
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME P.A. 2140 N. FULTON AVE., BALTIMORE, MD. 21217				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) JULY 29, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYANN D. KORENKO 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) AUG 07 1996		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 23390

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) STEVE STANFIELD				2. DATE OF DEATH MONTH DAY YEAR August 1, 1996		3. TIME OF DEATH 7:05 P M	
4. SOCIAL SECURITY NUMBER 212-88-4455		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 28 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUG. 13, 1967	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) STELLA MARIS AT MERCY		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
9c. COUNTY OF DEATH BALTIMORE				10a. STATE MARYLAND		10b. COUNTY BALTIMORE	
10c. CITY, TOWN OR LOCATION BALTIMORE CITY				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 19 S. ARLINGTON AVENUE	
10f. ZIP CODE 21223				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 + HIGHER GRADE College (1-4 or 5+) DEMOLITION WORKER				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DEMOLITION WORKER		16b. KIND OF BUSINESS/INDUSTRY DEMOLITION COMPANY	
17. FATHER'S NAME (First, Middle, Last) STERLING STANFIELD				18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNIE PEARSON			
19a. INFORMANT'S NAME (Type/Print) ANNIE STANFIELD				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 S. ARLINGTON AVE, BALTIMORE, MD. 21223			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARBUTUS CEMETERY 8-6-96		20c. LOCATION — City or Town, State ARBUTUS, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE, BALTIMORE, MD. 21217			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. End Stage AIDS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death YRS.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Kendall Faulkner			
29c. LICENSE NUMBER D25643				29d. DATE SIGNED (Month, Day, Year) 8/2/96			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD. TOWSON, MD 21204							
31. DATE FILED (Month, Day, Year) AUG 07 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 23391

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) NONA TURNIPSEED				2. DATE OF DEATH MONTH 08 DAY 05 YEAR 96		3. TIME OF DEATH 0840 AM	
4. SOCIAL SECURITY NUMBER 218-46-9889		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 52 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT. 26, 1943	
8a. FACILITY NAME (If not institution, give street and number) MERCY HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH BALTO. CITY	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY BALTO. CITY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 410 W. FRANKLIN STREET APT. 5B				10f. ZIP CODE 21201		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) COSMETOLOGIST		16b. KIND OF BUSINESS/INDUSTRY PRIVATE			
17. FATHER'S NAME (First, Middle, Last) SONIE TURNIPSEED				18. MOTHER'S NAME (First, Middle, Maiden Surname) ROBERTA CROSBY			
19a. INFORMANT'S NAME (Type/Print) PATRICE TURNIPSEED				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 334 E. 20th STREET BALTO., MD 21218			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING MEM & -10-96 RANDALLSTOWN, MD		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin L. Williams</i>				22. NAME AND ADDRESS OF FACILITY CALVIN L. WILLIAMS F.S. 270 FREDHILTON PASS BALTO., MD			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. myocardial infarction DUE TO (OR AS A CONSEQUENCE OF):					
		b. coronary artery disease DUE TO (OR AS A CONSEQUENCE OF):					
		c. diabetes mellitus DUE TO (OR AS A CONSEQUENCE OF):					
		d.					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. hypertension, end stage renal disease seizure d/o, sp @ CVA sp @ AKA							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kelly Fritz MD</i>				29c. LICENSE NUMBER D45333		29d. DATE SIGNED (Month, Day, Year) 08/05/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kelly Fritz MD DEPT. OF HEALTH & MENTAL HYGIENE 301 St Paul Pl. Baltimore MD 21202							
31. DATE FILED (Month, Day, Year) AUG 07 1996				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23392

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LEONARD AUGUSTUS TURNER

2. Date of Death

JULY 26, 1996

3. Time of Death

4:15

4a. Facility Name (If not institution, give street and number)

627 SOUTH PACA STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

216-30-6032

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JULY 14, 1936

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

627 South Paca Street

10f. Zip Code

21230

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

1 YEAR

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

ELECTRICIAN

16b. Kind of Business/Industry

BETHLEHEM STEEL CORP.

17. Father's Name (First, Middle, Last)

HOWARD A. TURNER

18. Mother's Name (First, Middle, Maiden Surname)

GERTRUDE A. BUSH

19a. Informant's Name/Relationship (Type, Print)

LYNETTE HAMLIN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

607 JASPER STREET, BALTIMORE, MD. 21201

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MT. CALVARY CEMETERY

Date

8-1-96

20c. Location - City or Town, State

GLEN BURNIE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME, P.A.
2140 N. FULTON AVENUE, BALTIMORE, MD. 2121723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. METASTATIC ESOPHAGAL CANCER (SQUAMOUS)

Approximate
Interval Between
Onset and Death

21 mos

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

William A. Foss MD; The Johns Hopkins Oncology Center 600 N. WILKES ST BALTIMORE MD 21287

31. Date filed (Month, Day, Year)

AUG 07 1996

32. Registrar's Signature

John Davidson

State
Registrar

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23393

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy

THAMERT

2. Date of Death
Month Day Year

August

6, 1996

3. Time of Death

2:42 a.m.

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital

4b. City, Town, or Location of Death

Rosedale

Baltimore

Funeral
Director

5. Social Security Number

212-01-9526

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

02/10/1914

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

MD.

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

103 Williams Ave.

10f. Zip Code

21222

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Walter Smith, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Unobtainable

19a. Informant's Name/Relationship (Type, Print)

Debbie Brown/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

103 Williams Ave. Dundalk, MD. 21222

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

8/7/96

20c. Location - City or Town, State

Beltsville, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bradley-Ashton Funeral Home, Inc.
2134 Willow Spring Rd. Balto. MD. 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End stage of Chronic Obstructive Pulmonary Disease

24 Hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28t. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D26835

29d. Date signed (Month, Day, Year)

8/6/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Valle M.D. 1012 Old North Point Road Baltimore, Maryland 21224

31. Date filed (Month, Day, Year)

AUG 07 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, a comparison of the results with previous research, and a conclusion about the significance of the study.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the limitations of the study, the strengths of the findings, and the potential for future research.

5. The fifth part of the report is a summary of the main findings of the study. It includes a brief overview of the research objectives, the methods used, the results obtained, and the conclusions drawn.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23394

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

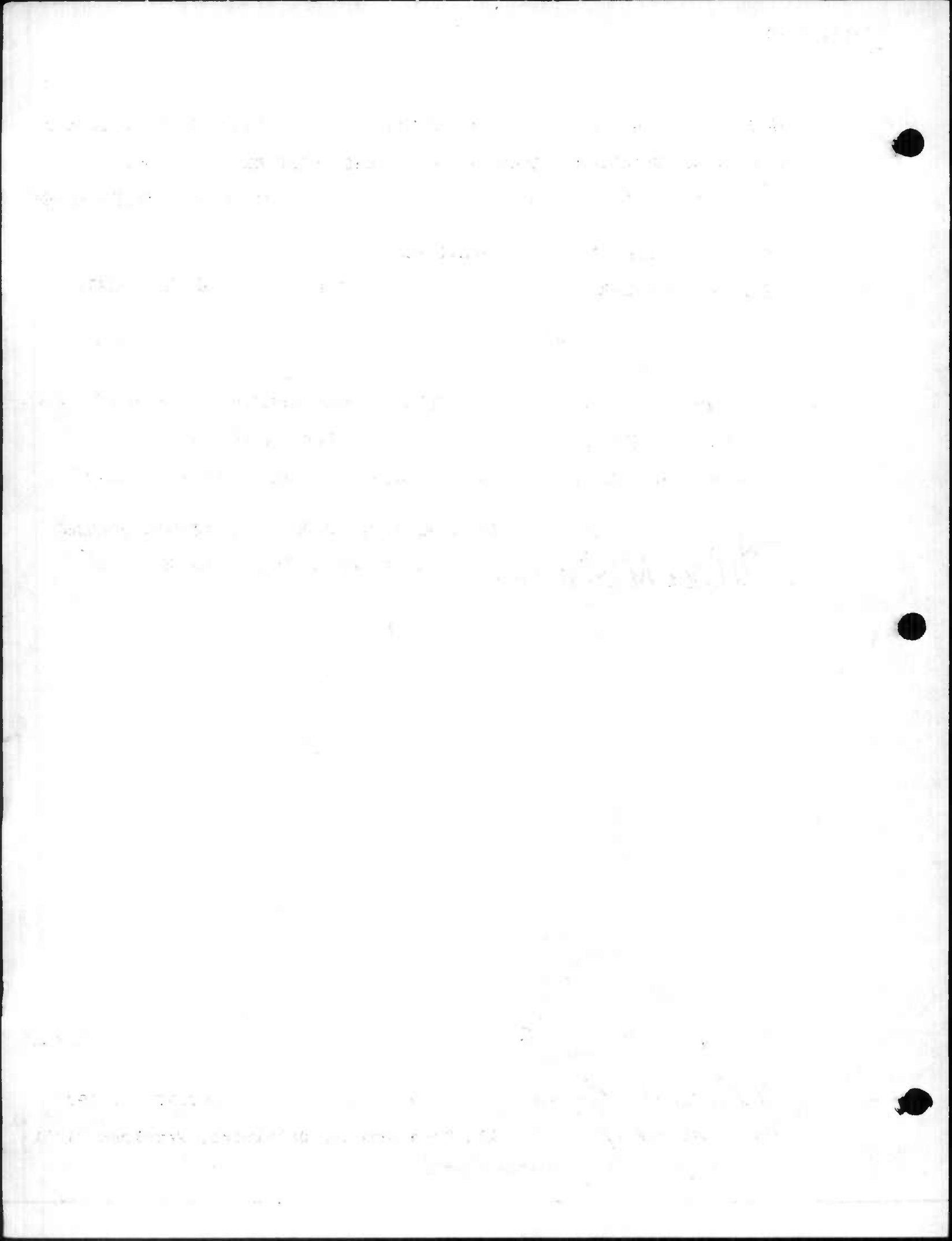
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) EARL LASHAWN WILLIAMS		2. Date of Death Month AUGUST Day 03 , Year 1996		3. Time of Death 0235AM
4a. Facility Name (If not institution, give street and number) 3100 BLOCK REMINGTON AVENUE-ALLEY		4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death n/a
5. Social Security Number 215-86-5522	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 21 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
8. Date of Birth (Month, Day, Year) JUN. 20, 1975		9. Birthplace (State or Foreign Country) BALTIMORE, MD		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10a. State MD	10b. County n/a	10c. City, Town or Location BALTIMORE		
10e. Street and Number 2706 MILES AVENUE		10f. Zip Code 21211		10g. Citizen of What Country? UNITED STATES
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 th Collage (1-4or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER (subcontractor)		16b. Kind of Business/Industry BETHLEHEM STEEL CORP.
17. Father's Name (First, Middle, Last) EARL WILLIAM SR.		18. Mother's Name (First, Middle, Maiden Surname) ETHEL DAVIS		
19a. Informant's Name/Relationship (Type, Print) EARL WILLIAMS SR.		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4012 KATHLAND AVENUE, BALTIMORE, MD 21207		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) VOSHALL MEMORIAL GARDENS 8010 DUNDALK, MARYLAND		Date
21. Signature of Funeral Service Licensee <i>Donald M. Davis</i>		22. Name and Address of Facility WM. C. MARCHFH.-1101 E. NORTH A VENUE		
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
Immediate Cause (Final disease or condition resulting in death) a. <i>Gunshot Wound to the Back</i> Due to (or as a consequence of):				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				
28a. Date of Injury (Month, Day, Year) Found 8/3/96				
28b. Time of Injury 1227 AM				
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
28d. Describe how injury occurred Subject shot				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) roadway				
28f. Location (Street and Number or Rural Route Number, City or Town, State) 3100 block Remington Avenue, Baltimore				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier <i>Theodore M. King</i>				
29c. License number O.C.M.E.				
29d. Date signed (Month, Day, Year) AUGUST 03, 1996				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201				
31. Date filed (Month, Day, Year) AUG 07 1996				
32. Registrar's Signature <i>Jana Davidson-Randall</i>				

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23395

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY M. WILLARD

2. Date of Death

Month

Day

Year

3. Time of Death

2:20 P.M.

4a. Facility Name (If not institution, give street and number)

Bons Secours Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

251-07-3296A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

July 21, 1911 SC

Usual Residence of Decedent

10a. State

NY

10b. County

n/a

10c. City, Town or Location

Staten Island

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2177 Eight Ave.

10f. Zip Code

10027

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Practical Nurse

16b. Kind of Business/Industry

Nursing

17. Father's Name (First, Middle, Last)

Joe Thomas

18. Mother's Name (First, Middle, Maiden Surname)

Melvina Holmes

19a. Informant's Name/Relationship (Type, Print)

Sarah Washington/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2810 Prestman St. Balto., MD 21216

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rose Hill Cemetery

Date

8/9

20c. Location - City or Town, State

Linden, New Jersey

21. Signature of Funeral Service Licensee

James A. Morton

22. Name and Address of Facility

James A. Morton & Sons Funeral Home

1701 Laurens St. Balto., MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Acute myocardial infarction

Approximate Interval Between Onset and Death

45 minutes

Due to (or as a consequence of):

b.

Chronic congestive heart failure

5 years

Due to (or as a consequence of):

c.

Atrial Fibrillation

6 months

Due to (or as a consequence of):

d.

Hypertensive coronary artery disease

10 years

Sequentially list conditions, if any, leading to Immediate Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Status post Nailing of Fractured @ distal femur 3 months

Normal pressure Hydrocephalus with Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Bernard N. Gonzalez Jr.

29c. License number

D18711

29d. Date signed (Month, Day, Year)

Aug. 5 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BERNARD N. GONZALEZ JR. MD

831 Poplar Grove Street, Baltimore, MD 21216

31. Date filed (Month, Day, Year)

AUG 07 1996

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

The law requires that the death certificate be executed within 24 hours after death. To the Hospital or Attending Physician: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the paper is devoted to a general discussion of the problem. It is shown that the problem is well-posed and that the solution exists and is unique.

2. In the second part, the problem is reduced to a system of ordinary differential equations. This is done by using the method of characteristics.

3. The third part of the paper is devoted to the construction of the solution. It is shown that the solution can be written in the form of a series.

4. In the fourth part, the convergence of the series is proved. It is shown that the series converges uniformly on the domain of interest.

5. The fifth part of the paper is devoted to the numerical solution of the problem. It is shown that the numerical solution can be obtained by using the method of finite differences.

6. In the sixth part, the results of the numerical solution are presented. It is shown that the numerical solution is in good agreement with the exact solution.

7. Finally, some conclusions are drawn. It is shown that the problem is well-posed and that the solution exists and is unique.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23396

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SYLVIA C. WANN				2. Date of Death Month AUGUST Day 5 Year 1996		3. Time of Death 2:00 am	
	4a. Facility Name (If not institution, give street and number) HOWARD COUNTY GENERAL HOSPITAL				4b. City, Town, or Location of Death COLUMBIA		4c. County of Death HOWARD	
Funeral Director	5. Social Security Number 212-18-9938	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) FEB. 11, 1911		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
10a. State MD		10b. County ANNE ARUNDEL		10c. City, Town or Location LINTHICUM			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 405 GROVE RIDGE COURT				10f. Zip Code 21090		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH GRADE College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OFFICE MANAGER			16b. Kind of Business/Industry UNION MEAT CUTTERS	
17. Father's Name (First, Middle, Last) LAWRENCE MATHISON					18. Mother's Name (First, Middle, Maiden Surname) THILDA ELKEANES			
19a. Informant's Name/Relationship (Type, Print) CAROL MEHRLING (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 GROVE RIDGE COURT - LINTHICUM, MD 21090				
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PK		Date 8/7/96		20c. Location - City or Town, State ELKCRIDGE	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229				
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Septic (Septic shock) Due to (or as a consequence of): b. Urosepsis Due to (or as a consequence of): c. Pneumonia Due to (or as a consequence of): d. Decubitus ulcer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate interval Between Onset and Death Days Days Days Days
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia hx of breast cancer hx of cerebrovascular accident						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred		
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier 			29c. License number D42892		29d. Date signed (Month, Day, Year) August 5 1996
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5999 Harper Farm Rd Ste 200E Columbia MD 21044								
31. Date filed (Month, Day, Year) AUG 07 1996			Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23397

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GRACIA G. WHITRIDGE

2. Date of Death

Month Day Year
AUGUST 5, 1996

3. Time of Death

7:45 AM.

4a. Facility Name (If not institution, give street and number)

UNION MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-03-8046

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
08-02-1909

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

830 WEST 40th. STREET

10f. Zip Code

21211

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12 YEARS

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

(UNKNOWN) GRIEB

18. Mother's Name (First, Middle, Maiden Surname)

(UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)

ANNE T. WHITRIDGE (SIS. IN LAW) 10610 BROOKLAWN RD., OWINGS MILLS, MD. 21117

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

SAINT THOMAS CH. CEM. 8-8-96 GARRISON FOREST, MD.

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

R. H. Rutter

22. Name and Address of Facility

HENRY W. JENKINS AND SONS COMPANY
4905 YORK ROAD, BALTIMORE, MARYLAND, 2121223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Acute Myocardial Infarction

6 hours

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

William D. McConnell M.D.

29c. License number

D42129

29d. Date signed (Month, Day, Year)

AUGUST 5, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

WILLIAM D. McCONNELL, M.D., 500 WEST UNIVERSITY PKWY., BALTO., MD. 21210

31. Date filed (Month, Day, Year)

AUG 07 1996

32. Registrar's Signature

L. Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

96 23398

FOR STATE REGISTRAR 10-08-96 J.A. STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 ITEM#27 PER DOCTOR FLMG740 CERTIFICATE OF DEATH REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EVELYN Williams				2. DATE OF DEATH MONTH August DAY 05 YEAR 1996		3. TIME OF DEATH 5:43AM	
4. SOCIAL SECURITY NUMBER 575-12-3658		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 14, 1914	
8a. FACILITY NAME (If not institution, give street and number) St. Elizabeths				8b. CITY, TOWN OR LOCATION OF DEATH Baltimore		8c. COUNTY OF DEATH N/A	
9a. RESIDENCE OF DECEDENT				9b. CITY, TOWN OR LOCATION			
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Catonsville		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 206 Slitting Mills Place				10f. ZIP CODE 21228		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary <input type="checkbox"/> Secondary (9-12) <input checked="" type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk		15b. KIND OF BUSINESS/INDUSTRY retail			
17. FATHER'S NAME (First, Middle, Last) unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) unknown			
19a. INFORMANT'S NAME (Type/Print) Charles E. Williams				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 Slitting Mills Place Catonsville, MD 21228			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory 8/6/96		20c. LOCATION — City or Town, State Catonsville, MD		20d. DATE 8/6/96	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Ambrose Funeral Home, Inc. Arbutus 1328 Sulphur Spring Road 21227			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinoma of breast a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death 2 yrs
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER William M. Russell M				29c. LICENSE NUMBER D30182		29d. DATE SIGNED (Month, Day, Year) AUGUST 5, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William M. Russell MD 3421 BENSON AVE BALTIMORE MD 21227							
31. DATE FILED (Month, Day, Year) AUG 07 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23399

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES WAGNER				2. Date of Death Month AUGUST Day 3 Year 1996		3. Time of Death 4 AM										
	4a. Facility Name (If not institution, give street and number) Northwest Hospital Center				4b. City, Town, or Location of Death Randalstown		4c. County of Death Baltimore										
Funeral Director	5. Social Security Number 219-34-4228		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 58 Yrs.		8. Date of Birth (Month, Day, Year) April 17, 1938										
	9. Birthplace (State or Foreign Country) New York		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Catonsville										
Usual Residence of Decedent		10e. Street and Number 2119 Rockwell Avenue		10f. Zip Code 21228		10g. Citizen of What Country? United States											
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) inspector		16b. Kind of Business/Industry State Government													
17. Father's Name (First, Middle, Last) Joseph A. Wagner				18. Mother's Name (First, Middle, Maiden Surname) Elouise Martine													
19a. Informant's Name/Relationship (Type, Print) Dorothy Wagner, wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2119 Rockwell Avenue Catonsville, MD 21228													
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date 8/6/96		20c. Location - City or Town, State Catonsville, MD											
21. Signature of Funeral Service Licensee		22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road 21227															
23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																	
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>SEPTICEMIA Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td>PERITONITIS Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>INTRA ABDOMINAL ABSCESS Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	SEPTICEMIA Due to (or as a consequence of):	Approximate Interval Between Onset and Death	b.	PERITONITIS Due to (or as a consequence of):	c.	INTRA ABDOMINAL ABSCESS Due to (or as a consequence of):	d.	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	SEPTICEMIA Due to (or as a consequence of):	Approximate Interval Between Onset and Death														
	b.	PERITONITIS Due to (or as a consequence of):															
	c.	INTRA ABDOMINAL ABSCESS Due to (or as a consequence of):															
	d.																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ANASTOMOTIC LEAK (COLON)						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown											
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No											
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Dr. Ray Depestre		29c. License number D 27157		29d. Date signed (Month, Day, Year) AUGUST, 3, 1996											
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) RAYNOLD DEPESTRE NORTHWEST HOSPITAL CENTER		31. Date filed (Month, Day, Year) AUG 07 1996															
		32. Registrar's Signature Julia Anderson-Randall															

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

96 23400

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Loretta Catherine Weinhold				2. Date of Death Month Day Year Aug. 5, 1996		3. Time of Death 1:45pm	
	4a. Facility Name (If not institution, give street and number) 8 Eugena Ave.				4b. City, Town, or Location of Death Essex		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 217-34-5110		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAY 28, 1917	
	9. Birthplace (State or Foreign Country) Maryland							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State Md.		10b. County Baltimore		10c. City, Town or Location Essex			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 8 Eugena Ave.				10f. Zip Code 21221		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry own home		
	17. Father's Name (First, Middle, Last) Anthony Bauhaus				18. Mother's Name (First, Middle, Maiden Surname) Loretta R. Cassidy			
	19a. Informant's Name/Relationship (Type, Print) Elizabeth King				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Eugena Ave. Baltimore MD. 21221			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart Of Jesus		Date 8/8/96		20c. Location - City or Town, State Baltimore MD.	
	21. Signature of Funeral Service Licensee R. Terry Connelly				22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarct, acute Due to (or as a consequence of): b. Ischemic Heart Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Dr. Bo Zow-Win				29c. License number D16728 Maryland		29d. Date signed (Month, Day, Year) 8/6/96		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Bo Zow-Win 8010 Belair Road Baltimore Md. 21236								
31. Date filed (Month, Day, Year) AUG 07 1996								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23401

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret H. Willis				2. Date of Death Month Day Year August 4, 1996		3. Time of Death 7:05 A.M.			
	4a. Facility Name (If not institution, give street and number) Sykesville Eldercare				4b. City, Town, or Location of Death Sykesville		4c. County of Death Carroll			
Funeral Director	5. Social Security Number 220 03 5473		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 14, 1900 Md	9. Birthplace (State or Foreign Country)		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Md.	10b. County Carroll	10c. City, Town or Location Sykesville			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	10e. Street and Number 7309 Second Ave.				10f. Zip Code 21784		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Domestic					
	17. Father's Name (First, Middle, Last) Unknown				18. Mother's Name (First, Middle, Maiden Surname) Unknown					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Cauley Harding				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19364 Cedar Crest Ct. N. Ft. Meyers Fla.					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation		Date 8/6/96		20c. Location - City or Town, State Hampstead, MD.			
	21. Signature of Funeral Service Licensee Harry W. Haight				22. Name and Address of Facility Haight Funeral Home P.O. Box 195 Sykesville, MD. 21784					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of): b. Arrhythmia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <div style="position: absolute; left: 300px; top: 550px; font-size: 40px;">}</div>								Approximate Interval Between Onset and Death One day Ten years	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Multi Infarct Dementia									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier [Signature] MD		29c. License number D33184		29d. Date signed (Month, Day, Year) August 6, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan Kushner 114 Business Center Drive Reisterstown, MD										
31. Date Filed (Month, Day, Year) AUG 07 1996										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

96 23402

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GEORGE WILLIAM YUTZY, II				2. Date of Death Month August Day 03 Year 1996		3. Time of Death 9.25 PM	
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital				4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A	
Funeral Director	5. Social Security Number 217-48-7355		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 44 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 10, 1951	
	9. Birthplace (State or Foreign Country) Baltimore, MD		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Annapolis	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1619 St. Margaret Road		10f. Zip Code 21401		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) G.E.D.		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Heavy Equipment Operator		16b. Kind of Business/Industry Contracting			
	17. Father's Name (First, Middle, Last) George William Yutzy		18. Mother's Name (First, Middle, Maiden Surname) Reatta May Henry		19. Informant's Name/Relationship (Type, Print) Sharon Yutzy/Sister			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Mausoleum 8/7/1996		20c. Location - City or Town, State Parkville, Maryland		21. Signature of Funeral Service Licensee 	
	22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Respiratory failure		Approximate Interval Between Onset and Death 6 hr		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ETOH Abuse		23d. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HTN		23e. Part IV. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hepatitis		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - In home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 		29c. License number AT248546B12		29d. Date signed (Month, Day, Year) 8/3/96			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZAZUI WANG Union Memorial Hospital Baltimore, MD 21218							
State Registrar	31. Date filed (Month, Day, Year) AUG 07 1996		32. Date of Death (Month, Day, Year) August 03 1996					

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State of Maryland / Department of Health and Mental Hygiene

96 23403

Certificate of Death

Reg. No.

Amended #5, 7/24/96,
NBS, Allegany County

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN A. ARMENTROUT					2. Date of Death Month Day Year July 23, 1996		3. Time of Death 7:42 A							
	4a. Facility Name (If not Institution, give street and number) Memorial Hospital					4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany							
Funeral Director	5. Social Security Number 220-10-6030		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Nov 25 1917		9. Birthplace (State or Foreign Country) Virginia						
	Usual Residence of Decedent														
10a. State Maryland		10b. County Allegany		10c. City, Town or Location Westernport				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
10e. Street and Number 275 Main St.					10f. Zip Code 21562		10g. Citizen of What Country? United States								
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4or 5+) 				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Columbia Gas Employee			16b. Kind of Business/Industry Natural Gas Industry								
17. Father's Name (First, Middle, Last) Granville Armentrout					18. Mother's Name (First, Middle, Maiden Summa) Settie Armentrout										
19a. Informant's Name/Relationship (Type, Print) Marguerite Armentrout- Wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 275 Main St., Westernport, Md. 21562										
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Philos Cemetery			Date 7-25-96		20c. Location - City or Town, State Westernport, Md.							
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Boal Funeral Home 111 Church St. Westernport, Md.										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. METABOLIC ENCEPHALOPATHY Due to (or as a consequence of): b. CHRONIC RENAL FAILURE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 7 days 1 year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CVA Atrial fibrillation Anemia CHF Cardiomyopathy										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)												
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred						
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier  Dr. N. Saheta		29c. License number D 17920		29d. Date signed (Month, Day, Year) July 23, 1996	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. N. Saheta Memorial Hospital Cumberland, MD 21502															
31. Date filed (Month, Day, Year) JUL 24 1996			32. Registrar's Signature 												

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

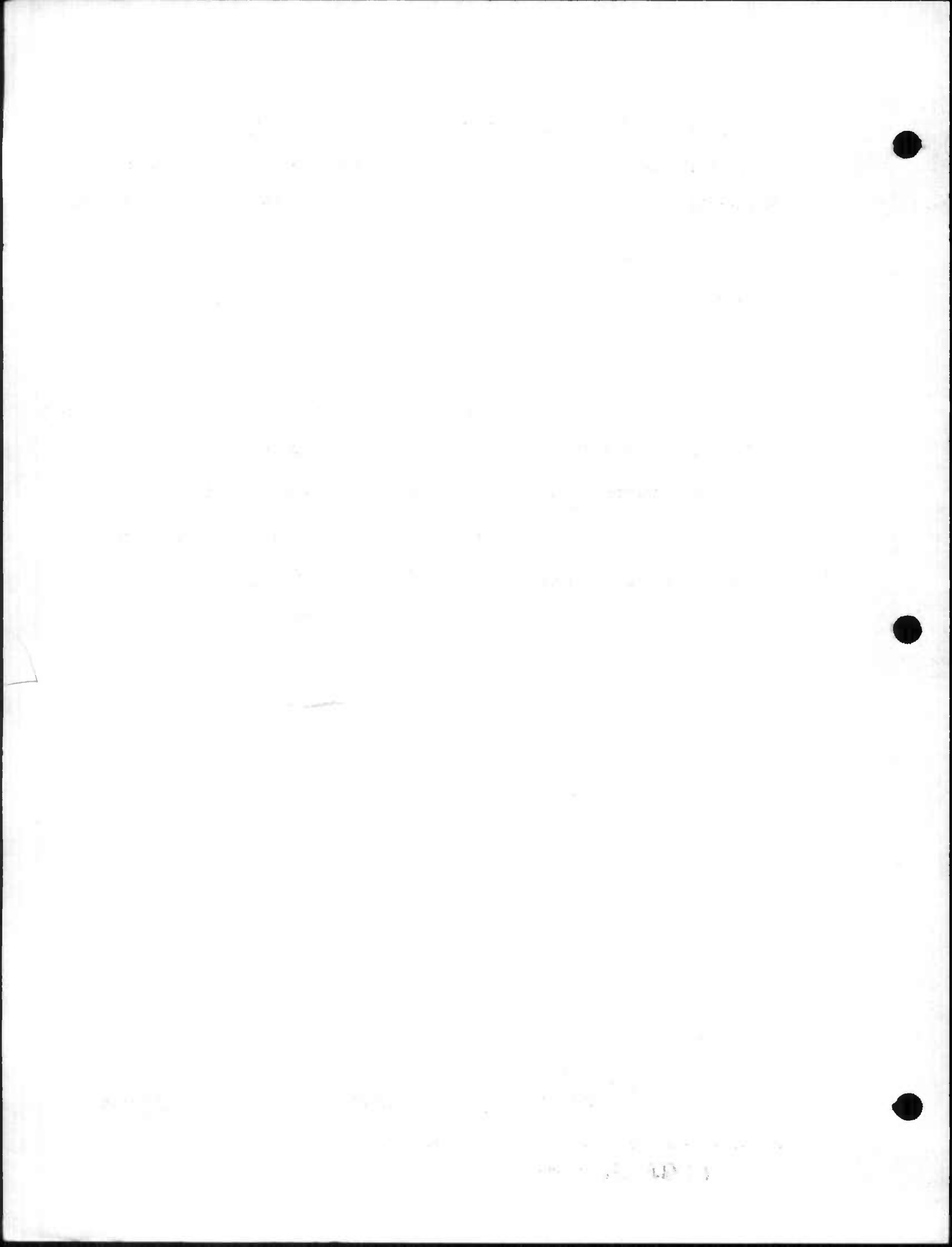
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) Harvey Ernest Baker				2. DATE OF DEATH MONTH July DAY 23, YEAR 1996				3. TIME OF DEATH 11:10P M	
4. SOCIAL SECURITY NUMBER 216-20-3380		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) June 12, 1926		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) VA Maryland Health Care System				9b. CITY, TOWN OR LOCATION OF DEATH Perry Point			9c. COUNTY OF DEATH Cecil		
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Havre de Grace			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER 123 Bloomsbury Avenue				10f. ZIP CODE 21078		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Civil Service		16b. KIND OF BUSINESS/INDUSTRY U.S. Government					
17. FATHER'S NAME (First, Middle, Last) Ernest Baker				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillie Boyd					
19a. INFORMANT'S NAME (Type/Print) Mrs. Mary Elizabeth Baker				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 123 Bloomsbury Avenue, Havre de Grace, MD 21078					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Holy Trinity Epis. Cemt. 7/27		DATE		20c. LOCATION — City or Town, State Churchville, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kristen Amy Unglesbee				22. NAME AND ADDRESS OF FACILITY Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gastrointestinal Bleed DUE TO (OR AS A CONSEQUENCE OF): b. Liver Cancer DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 2 hours unknown									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Hi Sup Sim MD				29c. LICENSE NUMBER D46412		29d. DATE SIGNED (Month, Day, Year) 07/23/96			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Hi Sup Sim, M.D. Perry Point, MD 21902									
31. DATE FILED (Month, Day, Year) JUL 25 1996		32. REGISTRAR'S SIGNATURE John Anderson-Randall							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23405

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARGARET G. Brooks				2. Date of Death Month Day Year July 20, 1996		3. Time of Death 1933	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 178-18-7792		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) FEB. 2, 1911	
	9. Birthplace (State or Foreign Country) PENNSYLVANIA		10a. State MARYLAND		10b. County WICOMICO		10c. City, Town or Location SALISBURY	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1514 RIVERSIDE DRIVE, B-101		10f. Zip Code 21801		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PAYROLL CLERK		16b. Kind of Business/Industry COMMERCIAL BAKERY			
	17. Father's Name (First, Middle, Last) EDMOND L. GRAF				18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH FOREMAN			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) MARY KAY BENN/DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 805 NORTH DIVISION STREET, SALISBURY, MD 21801			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) VALLEY FORGE MEM. GARDENS		20c. Location - City or Town, State KING OF PRUSSIA, PA		20d. Date 7/25	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Donald D. Zeller</i>				22. Name and Address of Facility ZELLER FUNERAL HOME, 106 MAIN STREET, P.O. BOX 3171, SALISBURY, MD 21802			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Refractory CHF / Cardiac Dysrhythmia - min weeks</i> Due to (or as a consequence of): <i>Cardiomyopathy</i> Due to (or as a consequence of): <i>Myocardial Infarction</i> Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>Dr. Joseph R. Fetto</i>				29c. License number D20441		29d. Date signed (Month, Day, Year) JULY 21, 1996	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Joseph R. Fetto, Quince St. 403, Salisbury, Md 21801							
State Registrar	31. Date filed (Month, Day, Year) JUL 24 1996		32. Registrar's Signature <i>John Anderson Randall</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

96 23406

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ARTHUR BERKNER Arthur Kurt Berkner				2. DATE OF DEATH MONTH July DAY 25 YEAR 96		3. TIME OF DEATH 4-03 PM	
4. SOCIAL SECURITY NUMBER 143-07-6806		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 22, 1908	
8. BIRTHPLACE (State or Foreign Country) Germany				9a. FACILITY NAME (If not Institution, give street and number) Dorchester General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Cambridge	
9c. COUNTY OF DEATH Dorchester				10a. STATE Maryland		10b. COUNTY Caroline	
10c. CITY, TOWN OR LOCATION Denton				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 25231 Adams Landing Road	
10f. ZIP CODE 21629				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: Caucasian				15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12 HS grad.			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Foundry Manager				16b. KIND OF BUSINESS/INDUSTRY Aeronautics			
17. FATHER'S NAME (First, Middle, Last) Kurt Bruno Berkner				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Siebert			
19a. INFORMANT'S NAME (Type/Print) Ruth Ann Crouse				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25231 Adams Landing Road, Denton, Maryland 21629			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Park George Washington Memorial 7/29			
20c. LOCATION — City or Town, State Paramus, New Jersey				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Randolph Moore</i>			
22. NAME AND ADDRESS OF FACILITY Moore Funeral Home, P.A. PO Drawer B, Denton, Maryland 21629				23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCTION Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. CORONARY ARTERY DISEASE c. ALZHEIMERS DISEASE d.			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>David A. Williamson MD</i>			
29c. LICENSE NUMBER D43756				29d. DATE SIGNED (Month, Day, Year) 7/25/96			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David A. Williamson, M.D., 511 Maryland Avenue, Cambridge, Maryland 21613							
31. DATE FILED (Month, Day, Year) 7/29/96				32. REGISTRAR'S SIGNATURE <i>Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 23407

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) (Maude T. Blank				2. DATE OF DEATH MONTH DAY YEAR July 25 1996				3. TIME OF DEATH 11:03 P M					
4. SOCIAL SECURITY NUMBER 213-22-3454		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb 3, 1916		8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not institution, give street and number) Cumberland Nursing Center						9b. CITY, TOWN OR LOCATION OF DEATH Cumberland			9c. COUNTY OF DEATH Allegany				
RESIDENCE OF DECEDENT													
10a. STATE Maryland			10b. COUNTY Allegany			10c. CITY, TOWN OR LOCATION Cumberland			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER Apt 1500B Oldtown Manor Oldtown Road						10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 6				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife				16b. KIND OF BUSINESS/INDUSTRY own home					
17. FATHER'S NAME (First, Middle, Last) Harvey Ray Kirby						18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Smith							
19a. INFORMANT'S NAME (Type/Print) Leslie J. Blank						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 719 Grand Ave., Cumberland, MD 21502							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or place of disposition) Mt. Savage Methodist Cem. July 28, 1996 Mt. Savage, MD				20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Douglas A. Hafer						22. NAME AND ADDRESS OF FACILITY Hafer Frost Mansion Funeral Home 58 Frost Ave., Frostburg, MD 21532							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CVA DUE TO (OR AS A CONSEQUENCE OF):													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):													
c. DUE TO (OR AS A CONSEQUENCE OF):													
d. DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Fever.													
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Peter Halvors MD				29c. LICENSE NUMBER D04981		29d. DATE SIGNED (Month, Day, Year) 7/27/1996			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PETER Halvors 302 Schlegel Cumberland, Md.													
31. DATE FILED (Month, Day, Year) JUL 29 1996				32. REGISTRAR'S SIGNATURE John D. ...									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23408

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ida Belle Bray			2. Date of Death Month Day Year JULY 23 1996			3. Time of Death 1:15 AM			
	4a. Facility Name (If not institution, give street and number) ALLEGANY CO. NURSING HOME			4b. City, Town, or Location of Death CUMBERLAND			4c. County of Death ALLEGANY			
Funeral Director	5. Social Security Number 214-32-3183		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 62 Yrs.		8. Date of Birth (Month, Day, Year) AUG 14 1933		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 106 SPRINGFIELD STREET				10f. Zip Code 21502		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collegia (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSE KEEPER			16b. Kind of Business/Industry HOUSE KEEPER		
	17. Father's Name (First, Middle, Last) FRANK RALEY				18. Mother's Name (First, Middle, Maiden Surname) CLARA MILLER					
	19a. Informant's Name/Relationship (Type, Print) GEORGE BRAY SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 47 KNOBLEY STREET RIDGELEY, W.VA. 26753					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KALBAUGH CEMETERY JULY 25 1996		Date JULY 25 1996		20c. Location - City or Town, State ELK GARDEN W.VA.			
	21. Signature of Funeral Service Licensee <i>Dale L. Merritt</i>				22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND 21502					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. <i>Cerebrovascular Accident</i> Due to (or as a consequence of):								
Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):										
c. Due to (or as a consequence of):										
d. Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Obstructive Hydrocephalus</i>										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>D. Barrera</i>		29c. License number 014865		29d. Date signed (Month, Day, Year) JULY 23, 1996				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. R. BARRERA MEMORIAL HOSPITAL CUMBERLAND MARYLAND 21502										
31. Date filed (Month, Day, Year) July 24 1996		32. Registrar's Signature <i>John Davidson Randall</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23409

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Madeline Barnhart						2. Date of Death Month Day Year July 19 1996			3. Time of Death 9:38 PM				
	4a. Facility Name (If not institution, give street and number) Apt 1104 Cumberland Manor Baltimore Street, Cumberland						4b. City, Town, or Location of Death Allegany			4c. County of Death Allegany				
Funeral Director	5. Social Security Number 214-07-2700		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) June 21, 1919		9. Birthplace (State or Foreign Country) Pennsylvania					
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State Maryland		10b. County Allegany		10c. City, Town or Location cumberland				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
	10e. Street and Number 229 Baltimore Ave. Apt. 1104				10f. Zip Code 21502		10g. Citizen of What Country? USA							
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		College (1-4or 5+)		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cafeteria worker			16b. Kind of Business/Industry Restaurant						
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Russell Barnhart						18. Mother's Name (First, Middle, Maiden Surname) Hulda Hartsock							
	19a. Informant's Name/Relationship (Type, Print) D. Glenn Barnhart / son						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44 Memorial Ave. EXT. Cumberland, Md. 21502							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Pleasant Grove Cemetery		Date 7-23-96		20c. Location - City or Town, State Cumberland, Md.							
	21. Signature of Funeral Service Licensee Ernest A. R. J.				22. Name and Address of Facility Leasure-Stein, Inc. 230 Baltimore Ave. Cumberland, Md. 21502									
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic cardiovascular heart disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. 										Approximate Interval Between Onset and Death uk yrs			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
	29b. Signature and title of certifier Dpty Med Ex				29c. License number D 09157				29d. Date signed (Month, Day, Year) July 19, 1996					
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Snow, M.D. 124 W 3rd St Cumb MD 21502													
	31. Date filed (Month, Day, Year) JUL 22 1996				32. Registrar's Signature John Davidson-Randall									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23410

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Susan Robin Cooney

2. Date of Death

Month Day Year
July 22, 1996

3. Time of Death

10:25 PM

4a. Facility Name (If not institution, give street and number)

1600 Wileywood Court

4b. City, Town, or Location of Death

Forest Hill

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

094-40-9856

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

46 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 4, 1949

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Forest Hill

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1600 Wileywood Court

10f. Zip Code

21050

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Quality Coordinator

16b. Kind of Business/Industry

Home Health Care

17. Father's Name (First, Middle, Last)

Samuel Unknown

Spielvogel

18. Mother's Name (First, Middle, Maiden Surname)

Annette Unknown

Gottlieb

19a. Informant's Name/Relationship (Type, Print)

Michael J. Cooney/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1600 Wileywood Court, Forest Hill, Maryland 21050

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Highview Memorial Gardens 7/26/96

Date

20c. Location - City or Town, State

Fallston, Maryland

21. Signature of Funeral Service Licensee

Stephen C. Hughes

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Md. 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MALIGNANT NEOPLASM UNKNOWN PRIMARY 2 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide

5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

n/a

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - (At home, farm, street, factory, office building, etc. (Specify))

n/a

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joan P. Edwards

29c. License number

D31775

29d. Date signed (Month, Day, Year)

July 23, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Joan P. Edwards, 2112 Belair Road, Fallston, Maryland 21047

31. Date filed (Month, Day, Year)

JUL 25 1996

32. Registrar's Signature

John Anderson-Rodell

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23411

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JANE ANNE CUNEO				2. Date of Death Month Day Year JULY 17 1996		3. Time of Death 4:38 AM																																														
	4a. Facility Name (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER				4b. City, Town, or Location of Death BETHESDA		4c. County of Death MONTGOMERY																																														
Funeral Director	5. Social Security Number 316-38-3292		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 57 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 6, 1938	9. Birthplace (State or Foreign Country) Indiana																																													
	Usual Residence of Decedent																																																				
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Gaithersburg		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																														
	10e. Street and Number 21010 Delta Drive				10f. Zip Code 20882		10g. Citizen of What Country? U.S.A.																																														
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White																																														
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own home.																																																
	17. Father's Name (First, Middle, Last) Kendall Allen Harrison				18. Mother's Name (First, Middle, Maiden Surname) Helen Copeland																																																
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) William J. Cuneo, Jr. - Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21010 Delta Drive, Gaithersburg, Maryland 20882																																																
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Dones/Other 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cem.		Date 7/25/96		20c. Location - City or Town, State Arlington, Virginia																																														
	21. Signature of Funeral Service Licensee <i>Robert L. Williams</i>		22. Name and Address of Facility Olin L. Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872																																																		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or organ failure. List only one cause on each line.																																																				
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="6">a. END STAGE RENAL DISEASE</td> <td>MONTHS</td> </tr> <tr> <td colspan="6">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td colspan="6">b. DIABETES</td> <td>YEARS</td> </tr> <tr> <td colspan="6">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="6">c.</td> <td></td> <td></td> </tr> <tr> <td colspan="6">d.</td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. END STAGE RENAL DISEASE						MONTHS	Due to (or as a consequence of):							Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. DIABETES						YEARS	Due to (or as a consequence of):							c.								d.						
Immediate Cause (Final disease or condition resulting in death)	a. END STAGE RENAL DISEASE						MONTHS																																														
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	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. DIABETES						YEARS																																													
		Due to (or as a consequence of):																																																			
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown																																														
							24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																																														
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																														
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)																																																			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred																																													
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																																																	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <i>D. L. Blazes MD</i>																																																			
		29c. License number RES-000		29d. Date signed (Month, Day, Year) 18 JUL 96																																																	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) D. L. BLAZES, LT, MC, USN		NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600																																																			
31. Date filed (Month, Day, Year) JUL 19 1996		32. Registrar's Signature <i>Davidson Randall</i>																																																			

Baltimore, Maryland 21215-0020

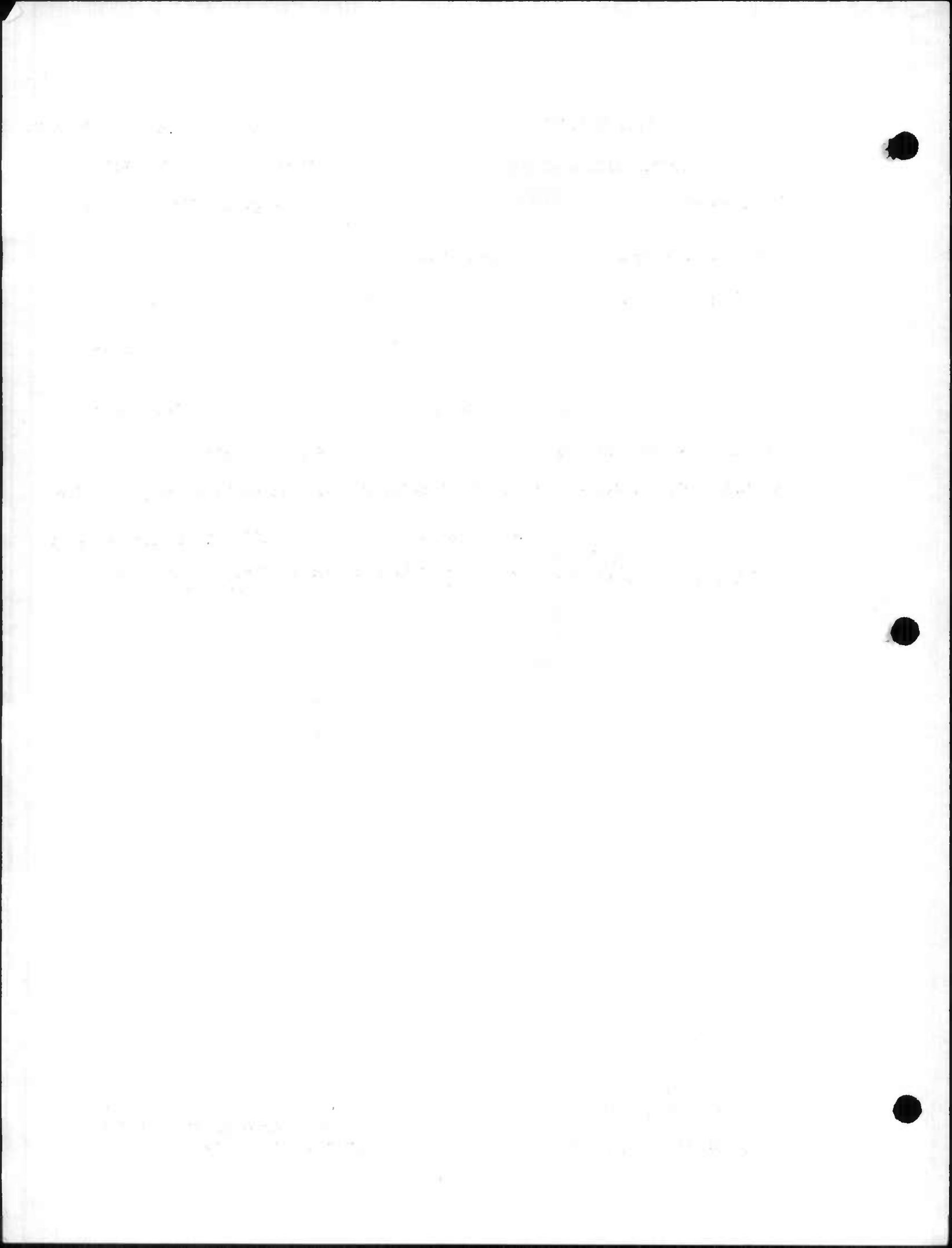
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23412

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ARVELLA HELEN CHANEY				2. Date of Death Month Day Year JULY 24, 1996		3. Time of Death 1900		
	4a. Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL				4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY		
Funeral Director	5. Social Security Number 214-07-6353		6. Sex 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81		8. Date of Birth (Month, Day, Year) Nov 14, 1914		
	9. Birthplace (State or Foreign Country) WV		10a. State MD		10b. County Allegany		10c. City, Town or Location Cumberland		
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 35 Mary Street		10f. Zip Code 21502		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Former Employee		16b. Kind of Business/Industry Textile				
	17. Father's Name (First, Middle, Last) Paul Phares				18. Mother's Name (First, Middle, Maiden Surname) Sally Kate (Warner)				
	19a. Informant's Name/Relationship (Type, Print) Earl E. Chaney--husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 Mary Street; Cumberland, MD 21502				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sunset Memorial Park		20c. Date 07/27		20d. Location - City or Town, State Cumberland, MD		
	21. Signature of Funeral Service Licensee <i>Nicholas J. Scarpelli</i>		22. Name and Address of Facility Scarpelli Funeral Home Cumberland, MD 21502						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Causa (Final disease or condition resulting in death) a. ACUTE ASPIRATION pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate interval Between Onset and Death 30 minutes	
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Congestive Heart Failure with pleural effusion							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28e. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>S. Chang MD</i>		29c. License number D 25836		29d. Date signed (Month, Day, Year) JULY 26, 1996			
30. Name and address of person who completed causa of death (Item 23e) (Type, Print) SATURNINA CHANG, M.D. RT 36 FROSTBURG PLAZA FROSTBURG MD 21532									
31. Date filed (Month, Day, Year) JUL 29 1996		32. Registrar's Signature <i>Johanna Davidson-Randall</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23413

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SADIE MAE DESHIELDS				2. Date of Death Month JULY Day 10 Year 1996				3. Time of Death 1020	
	4e. Facility Name (If not Institution, give street and number) 9852 Wallerstown Road				4b. City, Town, or Location of Death Mardela Springs Wicomico				4c. County of Death	
Funeral Director	5. Social Security Number Unknown		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) 04/23/07		9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Wicomico		10c. City, Town or Location Mardela Springs	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 9852 Wallerstown Road		10f. Zip Code 21837		10g. Citizen of What Country? United States		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 Collage (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farm Laborer	
To Be Completed by Physician/Medical Examiner	16b. Kind of Business/Industry Agriculture		17. Father's Name (First, Middle, Last) Hooper Cephas, Jr.		18. Mother's Name (First, Middle, Maiden Surname) Roxie Christian		19a. Informant's Name/Relationship (Type, Print) William Cephas, Jr.		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6080 Ocean Gateway, Easton, MD 21601	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Reids Grove Cemetery 7-16		20c. Location - City or Town, State Nr. Vienna, MD		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Frampton-Hawkins-Eskow Funeral Home PO Box 43, Federalsburg, MD 21632	
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. GENERALIZED ARTERIOSCLEROSIS Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death YEARS	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
State Registrar	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  D.M.E.	
	29c. License number D03599		29d. Date signed (Month, Day, Year) 07-11-96		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY, MD 21801		31. Date filed (Month, Day, Year) JUL 29 '96		32. Registrar's Signature 	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

96 23414

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Sister Dolores Doyle				2. DATE OF DEATH MONTH DAY YEAR July 18, 1996		3. TIME OF DEATH 9:50 A.M.	
4. SOCIAL SECURITY NUMBER 058-42-5105		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 4, 1912	
9a. FACILITY NAME (If not institution, give street and number) St. Joseph Provincial House				9b. CITY, TOWN OR LOCATION OF DEATH Emmitsburg, MD 21727		9c. COUNTY OF DEATH Frederick	
RESIDENCE OF DECEDENT				10c. CITY, TOWN OR LOCATION Washington		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10a. STATE D.C.		10b. COUNTY D.C.		10e. STREET AND NUMBER 1150 Varnum Street, N.E.		10f. ZIP CODE 20017-2180	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Social Work		16b. KIND OF BUSINESS/INDUSTRY Hospital			
17. FATHER'S NAME (First, Middle, Last) William Patrick Doyle				18. MOTHER'S NAME (First, Middle, Maiden Surname) Irene H. Young			
19a. INFORMANT'S NAME (Type/Print) Sister Camilla Harant				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 333 S. Seton Ave., Emmitsburg, MD 21727			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ST. JOSEPH'S, 7/20/96		20c. LOCATION — City or Town, State EMMITSBURG, MD. 21727			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE John M. Skiles				22. NAME AND ADDRESS OF FACILITY SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Anterior wall MI DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. Hypertension + Hypercholesterolemia DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death 12 hrs 20 yrs 30 yrs							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Fracture left occiput with fall at time of death.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Referral Center, St. Joseph Provincial House					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Undetermined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Bonita J. Krenzel-Porter D.O.				29c. LICENSE NUMBER H44037		29d. DATE SIGNED (Month, Day, Year) 7/18/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BONITA J. KRENZEL-PORTER D.O. 310 S. SETON AVE. EMMITSBURG, MD 21727							
31. DATE FILED (Month, Day, Year) JUL 18 1996				32. REGISTRAR'S SIGNATURE Kathleen Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23415

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NORA JANE DEATER				2. Date of Death Month JULY Day 16, Year 1996		3. Time of Death 12:16 PM	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 220-26-0559	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 9, 1922	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent							
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 200 Thomas Ave.				10f. Zip Code 21701		10g. Citizen of What Country? United States		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeping			16b. Kind of Business/Industry College	
17. Father's Name (First, Middle, Last) Harry Deater				18. Mother's Name (First, Middle, Maiden Surname) Fanny Maude Greenwald				
19a. Informant's Name/Relationship (Type, Print) Thomas Eaves / nephew				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Catoclin Ave. / Frederick, Maryland 21701				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery		20c. Date 7-19-96		20d. Location - City or Town, State Frederick, Maryland	
21. Signature of Funeral Service Licensee <i>Raymond Peterson</i>				22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike / Frederick, Maryland 21702				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Myocardial Infarction Due to (or as a consequence of):</p> <p>b. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p>immediate</p> <p>About 5 years</p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred		
			28e. Location (Street and Number or Rural Route Number, City or Town, State)					
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Robert M. Scovner M.D.				29c. License number D14724		29d. Date signed (Month, Day, Year) July 16, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert M. Scovner, M.D. 1603 B Berry Rose Court. Frederick, Md. 21701								
31. Date filed (Month, Day, Year) JUL 22 1996			32. Registrar's Signature <i>Jane Anderson-Randall</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 23416

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY WINIFRED DOLL				2. DATE OF DEATH MONTH July DAY 23 , YEAR 1996		3. TIME OF DEATH 11:25 P M	
4. SOCIAL SECURITY NUMBER 192-10-5204		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 91 YRS.	7. DATE OF BIRTH (Month, Day, Year) Mar 17, 1905		8. BIRTHPLACE (State or Foreign Country) MD	
9a. FACILITY NAME (If not institution, give street and number) DEVLIN MANOR NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		9c. COUNTY OF DEATH ALLEGANY	
10a. STATE WV		10b. COUNTY Mineral		10c. CITY, TOWN OR LOCATION Ridgeley		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER Route 1 Box 307				10f. ZIP CODE 26753		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bookkeeper		16b. KIND OF BUSINESS/INDUSTRY Doll Wood Estates			
17. FATHER'S NAME (First, Middle, Last) Bernard H. Doll				18. MOTHER'S NAME (First, Middle, Maiden Surname) Winifred Kilcoin			
19a. INFORMANT'S NAME (Type/Print) Betty Diehl				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 Country Villa; Keyser, WV 26726			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Patrick's Cemetery 07/27		20c. LOCATION — City or Town, State Cumberland, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Scarpelli				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. VENTRICULAR FIBRILLATION DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseases or Injury that inflamed events resulting in death) LAST { b. CORONARY HEART DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. OLD AGE DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 1 MINUTE 20 YRS 35 YRS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] M.D.				29c. LICENSE NUMBER D23334		29d. DATE SIGNED (Month, Day, Year) July 28, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dinesh Shah, M.D.; 625 Kent Avenue; Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) JUL 28 1996							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) OIEN CLYDE EDWARDS				2. Date of Death Month July Day 24 Year 1996		3. Time of Death 2:05pm	
4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital				4b. City, Town, or Location of Death Havre de Grace		4c. County of Death Harford	
5. Social Security Number 218-32-6837		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) June 18, 1917	
9. Birthplace (State or Foreign Country) North Carolina		10a. State Maryland		10b. County Harford		10c. City, Town or Location Havre de Grace	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 4009 Chapel Road		10f. Zip Code 21078		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Civil Service		16b. Kind of Business/Industry U.S. Government		17. Father's Name (First, Middle, Last) Commodore Edwards	
18. Mother's Name (First, Middle, Maiden Surname) Iona Wagoner		19a. Informant's Name/Relationship (Type, Print) Mrs. Barbara J. Edwards (daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2030 Chapel Road, Havre de Grace, MD 21078		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) Sparta Cemetery		20c. Date 7/28/96		20d. Location - City or Town, State Sparta, North Carolina		21. Signature of Funeral Service Licensee Kirsten Amy Unglesbee	
22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21007-3399		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Acute Pulmonary Edema Due to (or as a consequence of): b. Cardiomyopathy Due to (or as a consequence of): c. Coronary Artery Disease Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death Two weeks		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus Anemia H/o Cerebrovascular Accident		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier MIRZA A BAIG		29c. License number D43115		29d. Date signed (Month, Day, Year) 7-24-96	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							
31. Date filed (Month, Day, Year) JUL 25 1996		32. Registrar's Signature J. H. Anderson-Randall					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

96 23418

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) David E. Edwards				2. DATE OF DEATH MONTH July DAY 28 YEAR 1996		3. TIME OF DEATH 12:30 a. M	
4. SOCIAL SECURITY NUMBER 577-16-9764		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 18, 1921	
8. BIRTHPLACE (State or Foreign Country) Cambria Co., PA.				9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Cumberland	
9c. COUNTY OF DEATH Allegany				10a. STATE Maryland		10b. COUNTY Allegany	
10c. CITY, TOWN OR LOCATION Westernport				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 25701 Shady Lane, S.W.	
10f. ZIP CODE 21562				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4+			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Psychiatrist				16b. KIND OF BUSINESS/INDUSTRY Hospital Psychiatry			
17. FATHER'S NAME (First, Middle, Last) David E. Edwards, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Turgeon			
19a. INFORMANT'S NAME (Type/Print) Janet Sidor				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11819 N. Lincoln Avenue Beltsville, MD 20705			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE The Cumberland Crematory July 30, 1996			
20c. LOCATION — City or Town, State Cumberland, MD				21. SIGNATURE OF FUNERAL SERVICE LICENSEE Brian L. Smith			
22. NAME AND ADDRESS OF FACILITY Rotruck-Smith Funeral Home 85 S. Main Street Keyser, WV 26726				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → acute Respiratory Failure Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST acute Bacterial Pneumonia DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 24hr 24hr			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Emphysema				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Robert J. Orlino, M.D.				29c. LICENSE NUMBER D34846		29d. DATE SIGNED (Month, Day, Year) July 29, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert J. Orlino, M.D. 902 Seton Drive Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) JUL 29 1996				32. REGISTRAR'S SIGNATURE John Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23419

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Paul (NMN) Guercio

2. Date of Death

Month Day Year
July 22 1996

3. Time of Death

1:45 pm

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

218-32-3688

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

102 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 22, 1894

9. Birthplace (State or Foreign Country)

Sicily

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

422 South Main Street

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Owner/Operator

18b. Kind of Business/Industry

Retail Grocery Sales

17. Father's Name (First, Middle, Last)

Salvatore (nmn) Guercio

18. Mother's Name (First, Middle, Maiden Surname)

Carmela (nmn) Cammarata

19a. Informant's Name/Relationship (Type, Print)

Henry P. Guercio - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 148, Fallston, Md. 21047

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Ignatius Church Cem.

Date

7/25/96

20c. Location - City or Town, State

Hickory, Maryland

21. Signature of Funeral Service Licensee

Howard K. McComas III

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.
50 W. Broadway St., Bel Air, Md. 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Respiratory Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hour

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Aspiration Pneumonia

Due to (or as a consequence of):

2 weeks

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Gangrene left leg

Prostate carcinoma

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Kevin R. Snyder MD

29c. License number

D33642

29d. Date signed (Month, Day, Year)

July 22, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kevin L Snyder MD 754 Hickory Avenue Bel Air MD

31. Date filed (Month, Day, Year)

JUL 25 1996

32. Registrar's Signature
John A. Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Amended # 1 D.C. P.S. 7/16/96

96 23420

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ELISE PERRIN GRIFFIN				2. DATE OF DEATH MONTH DAY YEAR JULY 9 1996		3. TIME OF DEATH 935P M	
4. SOCIAL SECURITY NUMBER 251-42-2181		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1931 October 11,	
8. BIRTHPLACE (State or Foreign Country) South Carolina				9a. FACILITY NAME (If not institution, give street and number) Meridian Long Green Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City	
9c. COUNTY OF DEATH n/a				10a. STATE Maryland		10b. COUNTY n/a	
10c. CITY, TOWN OR LOCATION Baltimore City				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 115 East Melrose Avenue	
10f. ZIP CODE 21212				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housekeeper		16b. KIND OF BUSINESS/INDUSTRY Hospitals			
17. FATHER'S NAME (First, Middle, Last) (unknown)				18. MOTHER'S NAME (First, Middle, Maiden Surname) Charlie Mae Perrin			
19a. INFORMANT'S NAME (Type/Print) Alicia Marie Bynum (great Niece)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 126 Barnes Street, P.O. Box 2203, North Carolina 27878			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glenwood Cemetery/July 17, 1996		20c. LOCATION — City or Town, State Washington, D. C.		20d. DATE July 17, 1996	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Latney's Funeral Home, Inc. 3831 Georgia Avenue, N.W.; Washington, DC 20011			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Atherosclerotic Cardiovascular Disease Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death YEARS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Insulin Dependent Diabetes Mellitus Hypertension							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Fredric S. Sirkis M.D.				29c. LICENSE NUMBER D22645		29d. DATE SIGNED (Month, Day, Year) 7/10/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FREDRIC S. Sirkis M.D. 7151 HOLABIRD AVE. BALTO, MD. 21222							
31. DATE FILED (Month, Day, Year) JUL 16 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23421
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES LEONARD GALLIHER				2. Date of Death Month Day Year July 24, 1996		3. Time of Death 5:00 pm	
	4a. Facility Name (If not institution, give street and number) Memorial Hospital				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 220-14-8885		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) AUG 23 1925	
	9. Birthplace (State or Foreign Country) MARYLAND							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 13301 WINCHESTER ROAD				10f. Zip Code 21502		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWNER GROCERY STORE & SERVICE STATION GROCERY/RETAIL		16b. Kind of Business/Industry			
	17. Father's Name (First, Middle, Last) GEORGE W. GALLIHER				18. Mother's Name (First, Middle, Maiden Surname) IRENE E. TWIGG			
	19a. Informant's Name/Relationship (Type, Print) GRACE G. GALLIHER WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13301 WINCHESTER ROAD CUMBERLAND MARYLAND 21502			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CUMBERLAND CREMATORY		Date JULY 27 1996		20c. Location - City or Town, State CUMBERLAND MARYLAND	
	21. Signature of Funeral Service Licensee <i>Dale L. Merritt</i>				22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>concomitant artery disease</i> Due to (or as a consequence of): b. <i>anemia</i> Due to (or as a consequence of): c. <i>new pathology</i> Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last {							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D 36766		29d. Date signed (Month, Day, Year) July 1996		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. V. Poonai, 955 Frederick St., Cumberland, MD 21502								
31. Date filed (Month, Day, Year) JUL 26 1996		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 23422

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SAMUEL W. GLENN				2. DATE OF DEATH MONTH JULY DAY 20 YEAR 1996		3. TIME OF DEATH 5:10 P M	
4. SOCIAL SECURITY NUMBER 214013573		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8-28-10	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) Frostburg Village Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Frostburg, MD	
9c. COUNTY OF DEATH ALLEGANY				10a. STATE MARYLAND		10b. COUNTY ALLEGANY	
10c. CITY, TOWN OR LOCATION CUMBERLAND				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 13807 STONEPOINT ROAD SW	
10f. ZIP CODE 21502				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MACHINIST MILLWRIGHT		16b. KIND OF BUSINESS/INDUSTRY TEXTILE SPINNING DEPARTMENT	
17. FATHER'S NAME (First, Middle, Last) JOHN GLENN				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET WATKINSON			
19a. INFORMANT'S NAME (Type/Print) BONNIE ZILER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13803 STONEPOINT RD, SW, CUMBERLAND, MD 21502			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) REST LAWN MEMORIAL GARDENS DATE July 24, 1996		20c. LOCATION — City or Town, State LA VALE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Douglas A. Haffer</i>				22. NAME AND ADDRESS OF FACILITY HAFFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY. LA VALE, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → MEASTATIC CARCINOMA OF PROSTATE Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION, Gastrointestinal Bleeding							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Hedhu</i>				29c. LICENSE NUMBER D26907		29d. DATE SIGNED (Month, Day, Year) JULY 22, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. HARJIT SIDHU, 925 BISHOP WALSH DR, CUMBERLAND, MD 21502							
31. DATE FILED (Month, Day, Year) JUL 24 1996				REGISTRAR'S SIGNATURE <i>John Davidson Ruffell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 23423

DMMH 16 Nov 6/95

96 23424

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ARMOND EVANGER HAYWARD				2. DATE OF DEATH MONTH DAY YEAR July 23 1996		3. TIME OF DEATH 1541 M	
4. SOCIAL SECURITY NUMBER 220-12-0763		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 2 1926	
8a. FACILITY NAME (If not institution, give street and number) Dorchester General Hospital				8b. CITY, TOWN OR LOCATION OF DEATH Cambridge		8c. COUNTY OF DEATH Dorchester	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Dorchester		10c. CITY, TOWN OR LOCATION Wingate		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2257 Wingate-Bishops Head Rd.				10f. ZIP CODE 21675		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) waterman, carpenter,		16b. KIND OF BUSINESS/INDUSTRY self employed			
17. FATHER'S NAME (First, Middle, Last) Richard Burke Hayward				18. MOTHER'S NAME (First, Middle, Maiden Surname) Millie Ann Jones			
19a. INFORMANT'S NAME (Type/Print) Nancy S. Hayward / wife				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2257 Wingate-Bishops Head Rd., Wingate MD 21675			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dorchester Memorial Park 7/26		20c. LOCATION — City or Town, State Cambridge, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home, PA 700 Locust St., Cambridge, MD 21613			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Squamous Cell Carcinoma of lung with mets DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 6-8 weeks							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ch. Attrial Fib, CHF, Smoking, Pleural effusion							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D47520		29d. DATE SIGNED (Month, Day, Year) 7-23-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 10 Annapolis St., Cambridge, MD 21613, HARIO BURNETT, H.D.							
31. DATE FILED (Month, Day, Year) JUL 25 1996		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 23425

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Louise Adams Harden				2. DATE OF DEATH MONTH DAY YEAR July 29 1996				3. TIME OF DEATH 3:13 a m					
4. SOCIAL SECURITY NUMBER 215-20-0382				5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 1 1925		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) Wesleyan Nursing Center						9b. CITY, TOWN OR LOCATION OF DEATH Denton				9c. COUNTY OF DEATH Caroline			
10a. STATE Maryland				10b. COUNTY Caroline				10c. CITY, TOWN OR LOCATION Greensboro					
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 13162 Greensboro Road				10f. ZIP CODE 21639		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:					
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Employee medical claim clerk					
16b. KIND OF BUSINESS/INDUSTRY Playtex International				17. FATHER'S NAME (First, Middle, Last) George Adams				18. MOTHER'S NAME (First, Middle, Maiden Surname) Clara Tribbitt Adams					
19a. INFORMANT'S NAME (Type/Print) Henry J. Harden				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13162 Greensboro Road Greensboro, MD 21639									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greensboro Cemetery 7/31				20c. LOCATION — City or Town, State Greensboro, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Fleegle-Helfenbein Funeral Home P.O. Box 160 Greensboro, Maryland 21639									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (First disease or condition resulting in death) → a. <u>Renal failure</u> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.										Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER 052036		29d. DATE SIGNED (Month, Day, Year) 7/29/96					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gary J. Sprouse 2108 Red Apple Plz Chester, MD 21619													
31. DATE FILED (Month, Day, Year) JUL 30 '96				32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23426

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Wilbur Bertie Huddleson

2. Date of Death

Month Day Year
July 19, 1996

3. Time of Death

10:10 PM

4a. Facility Name (If not institution, give street and number)

5021 Whispering Pines Lane

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

347-26-6919

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
May 21, 1926

9. Birthplace (State or Foreign Country)

Iowa

Usual Residence of Decedent

10a. State

Md.

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

5021 Whispering Pines Lane

10f. Zip Code

21702

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates: 1951-1953

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:
White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

security guard

16b. Kind of Business/Industry

federal government

17. Father's Name (First, Middle, Last)

Wilber C. Huddleson

18. Mother's Name (First, Middle, Maiden Surname)

Estella Beers

19a. Informant's Name/Relationship (Type, Print)

Carl J. Huddleson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5021 Whispering Pines Lane, Frederick, Md. 21702

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Methodist Cemetery

Date

7/23

20c. Location - City or Town, State

Myersville, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donald B. Thompson Funeral Home
31 E. Main St., Middletown, Md. 21769

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MALIGNANT LARGE CELL LYMPHOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 1/2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC LYMPHOCYTIC LEUKEMIA

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No25. Was case referred to medical examiner?
☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D31761

29d. Date signed (Month, Day, Year)

7/23/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRIAN M. O'CONNOR, MD 501 WEST SEVENTH ST., FREDERICK, MD 21701

31. Date filed (Month, Day, Year)

JUL 24 1996

32. Registrar's Signature

State
Registrar

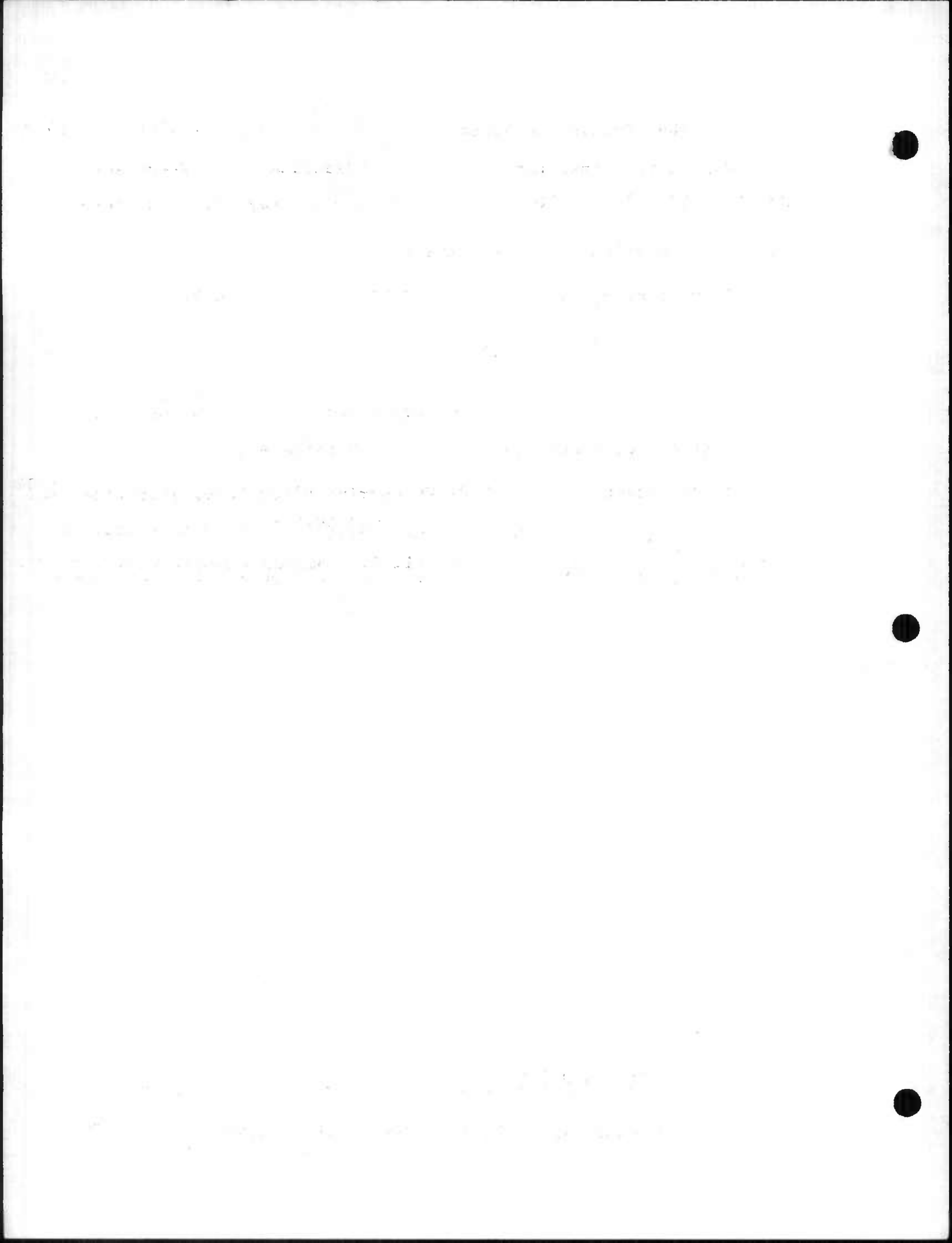
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23427

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Kenneth Ivan Harshman

2. Date of Death

Month Day Year
July 18, 1996

3. Time of Death

2:35 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

2430 Old National Pike

4b. City, Town, or Location of Death

Middletown

4c. County of Death

Frederick

5. Social Security Number

217-26-4263

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 10, 1926

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Frederick

10c. City, Town or Location

Middletown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2430 Old National Pike

10f. Zip Code

21769

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

barber

18b. Kind of Business/Industry

self-employed

17. Father's Name (First, Middle, Last)

William Ivan Harshman

18. Mother's Name (First, Middle, Maiden Surname)

Letha Summers

19a. Informant's Name/Relationship (Type, Print)

Mary Louise Harshman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2430 Old National Pike, Middletown, Md. 21769

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Grossnickle Cemetery 7/22

Date

20c. Location - City or Town, State

Myersville, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donald B. Thompson Funeral Home
31 E. Main St., Middletown, Md. 21769

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIOPULMONARY ARREST

Due to (or as a consequence of):

b. LIVER FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. CHRONIC ACTIVE HEPATITIS/CIRRHOSIS

Due to (or as a consequence of):

d. HEPATITIS B

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D41555

29d. Date signed (Month, Day, Year)

7/23/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

3019 VENTRIE CT MYERSVILLE, MD. 21773

State
Registrar

31. Date filed (Month, Day, Year)

JUL 24 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 502-3.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23428

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPHINE M. HARDEN

2. Date of Death

Month Day Year
JULY 18, 1996

3. Time of Death

5:40 p.m.

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral
Director

5. Social Security Number

212-84-1943

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb 15, 1926

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10e. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1214 Lafayette Avenue

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

white

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Joseph Crosby

18. Mother's Name (First, Middle, Maiden Surname)

Mildred (nmn)

19a. Informant's Name/Relationship (Type, Print)

Robert T. Harden--son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

30 Moran Avenue; Cumberland, MD 21502

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mary's Cemetery

Date

07/20

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

James F. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home
Cumberland, MD 21502Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC CORONARY ARTERY DISEASE 10 YEARS

Due to (or as a consequence of):

b. CARDIOMYOPATHY 3 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

N. Ranjithan M.D.

29c. License number

D 19318

29d. Date signed (Month, Day, Year)

JULY 22, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

N. RANJITHAN M.D. 517 Oldtown Road Cumberland, MD 21502

31. Date filed (Month, Day, Year)

JUL 24 1996

32. Registrar's Signature

John D. Ranjithan

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23429

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

ARLO

HAWK

2. Date of Death

Month

Day

Year

July 18, 1996

3. Time of Death

6:00 am

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

236-01-8696

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

April 8, 1917

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

GA

10b. County

Richmond

10c. City, Town or Location

Augusta

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1810 Fairview Avenue

10f. Zip Code

30904

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Repair Supervisor

16b. Kind of Business/Industry

Heavy Equipment

17. Father's Name (First, Middle, Last)

Frank M. Hawk

18. Mother's Name (First, Middle, Maiden Surname)

Erma Hanlin

19a. Informant's Name/Relationship (Type, Print)

Elsie Davis Hawk-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1810 Fairview Ave., Augusta, Georgia 30904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hillcrest Memorial Park July 20, 1996 Augusta, Georgia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joe E. Miller

22. Name and Address of Facility

Leasure-Stein Funeral Home
Cumberland, Md. 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ventricular Tachycardia

Due to (or as a consequence of):

IMMEDIATE

b. GI Bleeding Secondary to NSAID'S and Coumadin

Due to (or as a consequence of):

10 Days

c. Congestive Heart Failure

Due to (or as a consequence of):

4 Days

d. Coronary Artery Disease

Due to (or as a consequence of):

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes, Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. H. Shakil MD

29c. License number

D 46346

29d. Date signed (Month, Day, Year)

July 18, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. H. Shakil, Johnson Heights Medical Bldg., Cumberland, MD 21502

31. Date filed

JUL 22 1996

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23430

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT CHARLES HUFFMAN				2. Date of Death Month Day Year JULY 21, 1996		3. Time of Death 0600 A	
	4a. Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL				4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 201-24-1228	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec 30, 1931		9. Birthplace (State or Foreign Country) PA
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County Allegany	10c. City, Town or Location LaVale			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 828 National Highway			10f. Zip Code 21502		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korean		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Shipping Dept.			16b. Kind of Business/Industry Tire Company	
	17. Father's Name (First, Middle, Last) Nealson Huffman				18. Mother's Name (First, Middle, Maiden Surname) Blanche (Ranker)			
	19a. Informant's Name/Relationship (Type, Print) Gayle Tressler				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 828 National Highway; LaVale, MD 21502			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Frostburg Memorial Park		Data 07/23		20c. Location - City or Town, State Frostburg, MD	
	21. Signature of Funeral Service Licensee James F. Scarpelli				22. Name and Address of Facility Scarpelli Funeral Home Cumberland, MD 21502			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Causa (Final disease or condition resulting in death) a. Abdominal ileus Due to (or as a consequence of): b. peritonitis Due to (or as a consequence of): c. possible diverticulitis Due to (or as a consequence of): d.							
	Approximate Interval Between Onset and Death 4 day							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. severe pulm - emphysema Ischemic bowel disease						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Dr. [Signature] MD					
			29c. License number 1703459		29d. Date signed (Month, Day, Year) JULY 22 1996			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) R. ESPINA MD 902 SETON DR, CUMBERLAND, Md.							
State Registrar	31. Date filed (Month, Day, Year) JUL 23 1996				32. Registrar's Signature John Davidson-Randall			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23431

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VIOLA

VIRGINIA

JACKSON

2. Date of Death

Month
JULYDay
15,Year
1996

3. Time of Death

6:00 AM

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

214-16-0879

6. Sex

1 ☐ M2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Sept. 18, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

785 Wimbly Dr.

10f. Zip Code

21701

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

To Be Completed by Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7th

College (1-4or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Stock Clerk

16b. Kind of Business/Industry

Department Store

17. Father's Name (First, Middle, Last)

Sylvester

Young

18. Mother's Name (First, Middle, Maiden Surname)

Jenny

Pines

19a. Informant's Name/Relationship (Type, Print)

Helen Jackson/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

126 B, W. South St./ Frederick, Maryland 21701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fairview Cemetery

Date

7-19-96

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stauffer Funeral Home

1621 Opossumtown Pike, Frederick, Maryland 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CEREBRO VASCULAR ACCIDENT

Due to (or as a consequence of):

b. STATUS EPILEPTICUS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 Days

6 Days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D43091

29d. Date signed (Month, Day, Year)

7-15-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAEED ZAIDI

801 TOLL HOUSE AVE,

FREDERICK.

31. Date filed (Month, Day, Year)

JUL 22 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23432

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RICHARD SLYVESTER JONES

2. Date of Death

JULY 26, 1996

3. Time of Death

06:40 AM

4a. Facility Name (If not institution, give street and number)

SACRED HEART HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

5. Social Security Number

214 07 3257

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

AUG. 19, 1914

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

FROSTBURG

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

129 S. WATER STREET

10f. Zip Code

21532

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SERVICE DEPT.

16b. Kind of Business/Industry

CELANESE CORP

17. Father's Name (First, Middle, Last)

JOSEPH C. JONES

18. Mother's Name (First, Middle, Maiden Surname)

FLORA FRYE

19a. Informant's Name/Relationship (Type, Print)

JUNE JONES / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

129 W. WATER ST., FROSTBURG, MD 21532

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FROSTBURG MEMORIAL PK 7/29/96

Date

20c. Location - City or Town, State

FROSTBURG, MD 21532

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

SOWERS FUNERAL HOME, P.A.

60 W. MAIN ST., FROSTBURG, MD 21532

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. BILATERAL SUBDURAL HEMATOMA 4 MONTHS

Due to (or as a consequence of):

b. ACUTE CEREBRAL INFARCTION 4 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC ATRIAL FIBRILLATION
CA OF THE PROSTATE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

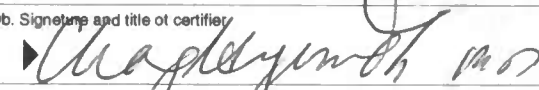
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D24951

29d. Date signed (Month, Day, Year)

JULY 26, 1996

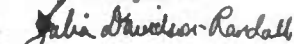
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CHANG-HYUN OH, M.D. 48 TARN TERRACE, FROSTBURG, MD 21532

31. Date filed (Month, Day, Year)

JUL 30 1996

32. Registrar's Signature


State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and to the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

96 23433

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mollie Roller Kennedy				2. DATE OF DEATH MONTH DAY YEAR July 27 1996		3. TIME OF DEATH 2:05 a M	
4. SOCIAL SECURITY NUMBER 245-22-0971		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 30, 1911	
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Easton		9c. COUNTY OF DEATH Talbot	
10a. STATE Maryland				10b. COUNTY Queen Anne		10c. CITY, TOWN OR LOCATION Chester	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER Apt #37 Sherman Way			
10f. ZIP CODE 21619				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (14 or 5+) 9				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Waitress		16b. KIND OF BUSINESS/INDUSTRY restaurant	
17. FATHER'S NAME (First, Middle, Last) Henry T. Roller				18. MOTHER'S NAME (First, Middle, Maiden Surname) Carolyn C. Bennett Roller			
19a. INFORMANT'S NAME (Type/Print) Patricia A. Cave				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Tennessee Road Stevensville, Maryland 21666			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cheltenham Veteran Cem 8/2		20c. LOCATION — City or Town, State Cheltenham, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Heidi C. Fleda</i>				22. NAME AND ADDRESS OF FACILITY Fleegle-Helfenbein Funeral Home P.O. Box 160 Greensboro, MD 21639			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Pneumonia</u> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <u>Transition</u> c. <u>Dementia</u> d. <u></u>							Approximate Interval Between Onset and Death <u>1 wk</u>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Dementia</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>G. J. Sprouse</i>			
29c. LICENSE NUMBER 032036				29d. DATE SIGNED (Month, Day, Year) 7/29/96			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gary J. Sprouse, MD 2108 Red Apple Plz Chester, MD 21619							
31. DATE FILED (Month, Day, Year) JUL 30 96				32. REGISTRAR'S SIGNATURE <i>J. A. Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23434
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Raisa Kosbun				2. Date of Death Month Day Year July 21, 1996		3. Time of Death 2 P. M.	
	4a. Facility Name (If not institution, give street and number) 7423 Round Hill Rd.				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 122-26-2314		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 99 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 29, 1896	
	9. Birthplace (State or Foreign Country) Russia		10a. State Md.		10b. County Frederick		10c. City, Town or Location Frederick	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 7423 Round Hill Rd.		10f. Zip Code 21702	
	10g. Citizen of What Country? Russia				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker			
	16b. Kind of Business/Industry own home				17. Father's Name (First, Middle, Last) Nikolai Kosbun			
	18. Mother's Name (First, Middle, Maiden Surname) Unknown				19a. Informant's Name/Relationship (Type, Print) Kira I. Redeen			
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7423 Round Hill Rd., Frederick, Md. 21702				20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			
	20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Memorial Gardens				20c. Location - City or Town, State Frederick, Md.			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. 21769			
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. GASTROINTESTINAL HEMORRHAGE				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
23c. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CONGESTIVE HEART FAILURE				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				
28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M				
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred				
28e. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier 				29c. License number D20488				
29d. Date signed (Month, Day, Year) 7-25-96				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES L. ROESSLER MD. PO BOX 17 MIDDLETOWN, MD. 21769				
31. Date filed (Month, Day, Year) JUL 25 1996				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified and all

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Page 10

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23435

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES ALFRED KOELKER SR.						2. Date of Death Month Day Year JULY 25 1996		3. Time of Death 5:25 A.M.		
	4a. Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL						4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY		
Funeral Director	5. Social Security Number 220-26-9328		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) NOV 28 1931		9. Birthplace (State or Foreign Country) MARYLAND		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 403 PENN. AVE.				10f. Zip Code 21502		10g. Citizen of What Country? U.S.A.				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: U.S. NAVY		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PITTSBURGH PLATE GLASS CO.			16b. Kind of Business/Industry MANUF GLASS			
	17. Father's Name (First, Middle, Last) JOSEPH H. KOELKER						18. Mother's Name (First, Middle, Maiden Surname) ADA LAYMAN				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) CHARLES A. KOELKER, JR. SON						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 816 HILL TOP DRIVE CUMBERLAND MARYLAND 21502				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) ROCKY GAP VET CEMETERY JULY 29 1996 RFD FLINTSTONE MD.			Data		20c. Location - City or Town, State		
	21. Signature of Funeral Service Licensee Dale L. Merritt						22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND 21502				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION Due to (or as a consequence of): b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____										1 HOUR 10 YEARS
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. OBESITY							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier Donald Manger M D OME				29c. License number DU 9231		29d. Date signed (Month, Day, Year) JULY 25, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DONALD MANGER OME 11600 BEDFORD ROAD NE CUMBERLAND MARYLAND 21502											
31. Date filed (Month, Day, Year) JUL 28 1996			32. Registrar's Signature Julia Anderson Randall								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 23436

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARIAN V. KIDWELL				2. DATE OF DEATH MONTH DAY YEAR JULY 20 1996		3. TIME OF DEATH 5:20 A^M	
4. SOCIAL SECURITY NUMBER 219-46-0546		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1917 DECEMBER 31	
8. BIRTHPLACE (State or Foreign Country) WEST VIRGINIA				9a. FACILITY NAME (If not institution, give street and number) CUMBERLAND NURSING CENTER		9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND	
9c. COUNTY OF DEATH ALLEGANY				10a. STATE MARYLAND		10b. COUNTY ALLEGANY	
10c. CITY, TOWN OR LOCATION CRESAPTOWN				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 14900 LEE STREET	
10f. ZIP CODE 21502				10g. CITIZEN OF WHAT COUNTRY? U S A			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) JOHN THOMPSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) LUCINDA KELSO			
19a. INFORMANT'S NAME (Type/Print) JOANN DICKINSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26719 P.O. BOX 674 FORT ASHBY, WEST VIRGINIA			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) RESTLAWN MEMORIAL GAR. 7/22		OATE		20c. LOCATION — City or Town, State LAVALE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Douglas A. Held</i>				22. NAME AND ADDRESS OF FACILITY HAFFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY LAVALE, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Chronic obstructive lung disease DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death 10 years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Recto vesicular fistula						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D33280		29d. DATE SIGNED (Month, Day, Year) July 22, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SUNIL K. GUPTA M.D. 625 KENT AVE. CUMBERLAND, MARYLAND 21502							
31. DATE FILED (Month, Day, Year) JUL 24 1996				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

U.S. DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D.C. 20250

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96 23437

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) STELLA E. KERCHNER				2. DATE OF DEATH MONTH DAY YEAR July 18, 1996		3. TIME OF DEATH 11:45 P M	
4. SOCIAL SECURITY NUMBER 202-46-3155		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jul 4, 1910	
9a. FACILITY NAME (If not institution, give street and number) DEVLIN MANOR NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		9c. COUNTY OF DEATH ALLEGANY	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 60 Browning Street				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Martin Mohoska				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary (nmn)			
19a. INFORMANT'S NAME (Type/Print) Frank P. Kerchner				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60 Browning Street; Cumberland, MD 21502			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Mary's Cemetery		DATE 07/22		20c. LOCATION — City or Town, State McKees Rocks, PA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Nicholas J. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY Scarpelli F.H. for McDermott F.H. Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → advanced spinal motor neuron disease							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
a. DUE TO (OR AS A CONSEQUENCE OF): urinary tract infection b. DUE TO (OR AS A CONSEQUENCE OF): stroke c. DUE TO (OR AS A CONSEQUENCE OF): gastro. physia d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: In the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>(for M. Poonai)</i>				29c. LICENSE NUMBER D36766		29d. DATE SIGNED (Month, Day, Year) 7/19/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Vik Poonai; 955 Frederick Street; Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) JUL 22 1996				32. REGISTRAR'S SIGNATURE <i>John Anderson-Rodell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23438

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Helen Virginia Kirby				2. Date of Death Month Day Year July 21, 1996				3. Time of Death 3:25 PM						
	4a. Facility Name (If not institution, give street and number) 5174 Wesley Road				4b. City, Town, or Location of Death Hurlock				4c. County of Death Dorchester						
Funeral Director	5. Social Security Number 218-20-3307		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth Month Day Year Feb 8, 1922		9. Birthplace (State or Foreign Country) Maryland						
	Usual Residence of Decedent														
To Be Completed by Funeral Director	10a. State Maryland		10b. County Dorchester		10c. City, Town or Location Cambridge				10d. Inside City Limits X <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						
	10e. Street and Number 215 Killarney Road				10f. Zip Code 21613		10g. Citizen of What Country? US								
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Deputy Clerk			16b. Kind of Business/Industry Co. Circuit Court							
	17. Father's Name (First, Middle, Last) Thomas Leonard Phillips				18. Mother's Name (First, Middle, Maiden Surname) Lena McNamara										
	19a. Informant's Name/Relationship (Type, Print) William V. Herd/Nephew				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 Truslow Road Chestertown, Maryland 21620										
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dorchester Memorial Park		Data 7/24/96		20c. Location - City or Town, State Cambridge, Maryland								
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Metastatic ovarian carcinoma</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death months				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <u>Hospice Care Home</u>					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred							
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier <u>Mary Ann D. Moore MD</u>		29c. License number <u>D31766</u>		29d. Date signed (Month, Day, Year) <u>7-23-96</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>MARY ANN D. MOORE, M.D. 408 BYRN ST. - CAMBRIDGE, MD 21613</u>															
31. Date filed (Month, Day, Year) <u>JUL 24 1996</u>		32. Registrar's Signature <u>Johanna Anderson-Randall</u>													

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, a comparison of the results with previous research, and a conclusion about the significance of the study.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the limitations of the study and suggestions for future research.

5. The fifth part of the report is a summary of the study. It includes a brief overview of the main findings and a final conclusion.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23439

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Milton Lane

2. Date of Death

Month Day Year
July 24 1996

3. Time of Death

4:41am

4a. Facility Name (If not institution, give street and number)

Memorial Hospital at Easton

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral
Director

5. Social Security Number

217-36-1241

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)
06/13/17

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Caroline

10c. City, Town or Location

Preston

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

22859 Dover Bridge Road

10f. Zip Code

21655

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Parts Salesman

16b. Kind of Business/Industry

Ford Dealer

17. Father's Name (First, Middle, Last)

Edward V. Lane

18. Mother's Name (First, Middle, Maiden Surname)

Mary Catherine Wright

19a. Informant's Name/Relationship (Type, Print)

Mary Vickers Lane

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22859 Dover Bridge Rd., Preston, MD 21655

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Junior Order Cemetery 7/27

Date

20c. Location - City or Town, State

Preston, Maryland

21. Signature of Funeral Service Licensee

Michael F. Eskow

22. Name and Address of Facility

Frampton-Hawkins-Eskow Funeral Home
PO Box 43, Federalsburg, MD 21632

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

PNEUMONIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

DAYS

b.

PROGRESSIVE PULMONARY FIBROSIS

Due to (or as a consequence of):

YEARS

c.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CAD

H/O Colon Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kevin O'Keefe MD

29c. License number

D35259

29d. Date Signed (Month, Day, Year)

7/24/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kevin O'Keefe, M.D., 606 Dutchman's Lane, Easton, MD 21601

31. Date filed (Month, Day, Year)

JUL 29 '96

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Certificate of Death

Reg. No.

1. Decedent's Name (First, Middle, Last) Frederick G. Long, Sr.		2. Date of Death Month July Day 22 Year 1996		3. Time of Death 8:00am					
4a. Facility Name (If not institution, give street and number) 11532 Windsor Road			4b. City, Town, or Location of Death Ijamsville		4c. County of Death Frederick				
5. Social Security Number 577-01-4849		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 3, 1916		9. Birthplace (State or Foreign Country) Ohio	
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Ijamsville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 11532 Windsor Road			10f. Zip Code 21754		10g. Citizen of What Country? United States				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Police officer			16b. Kind of Business/Industry Police Department			
17. Father's Name (First, Middle, Last) George Frederick Long			18. Mother's Name (First, Middle, Maiden Surname) Theresa Sampson						
19a. Informant's Name/Relationship (Type, Print) Frederick G. Long Jr.-Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11532 Windsor Road, Ijamsville Md. 21754						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Washington National Cemetery		20c. Location - City or Town, State 7/26 Suitland, Maryland.					
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Olin L. Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117							
23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): 2 Coronary Heart Disease b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death 9-92				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred							
28e. Location (Street and Number or Rural Route Number, City or Town, State)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 		29c. License number 0-12191		29d. Date signed (Month, Day, Year) July 22, 1996					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arthur G. Manalo, M.D. 11801 Fingerboard Road, Monrovia, Maryland 21770									
31. Date filed (Month, Day, Year) JUL 24 1996		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

**State
Registrar**

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

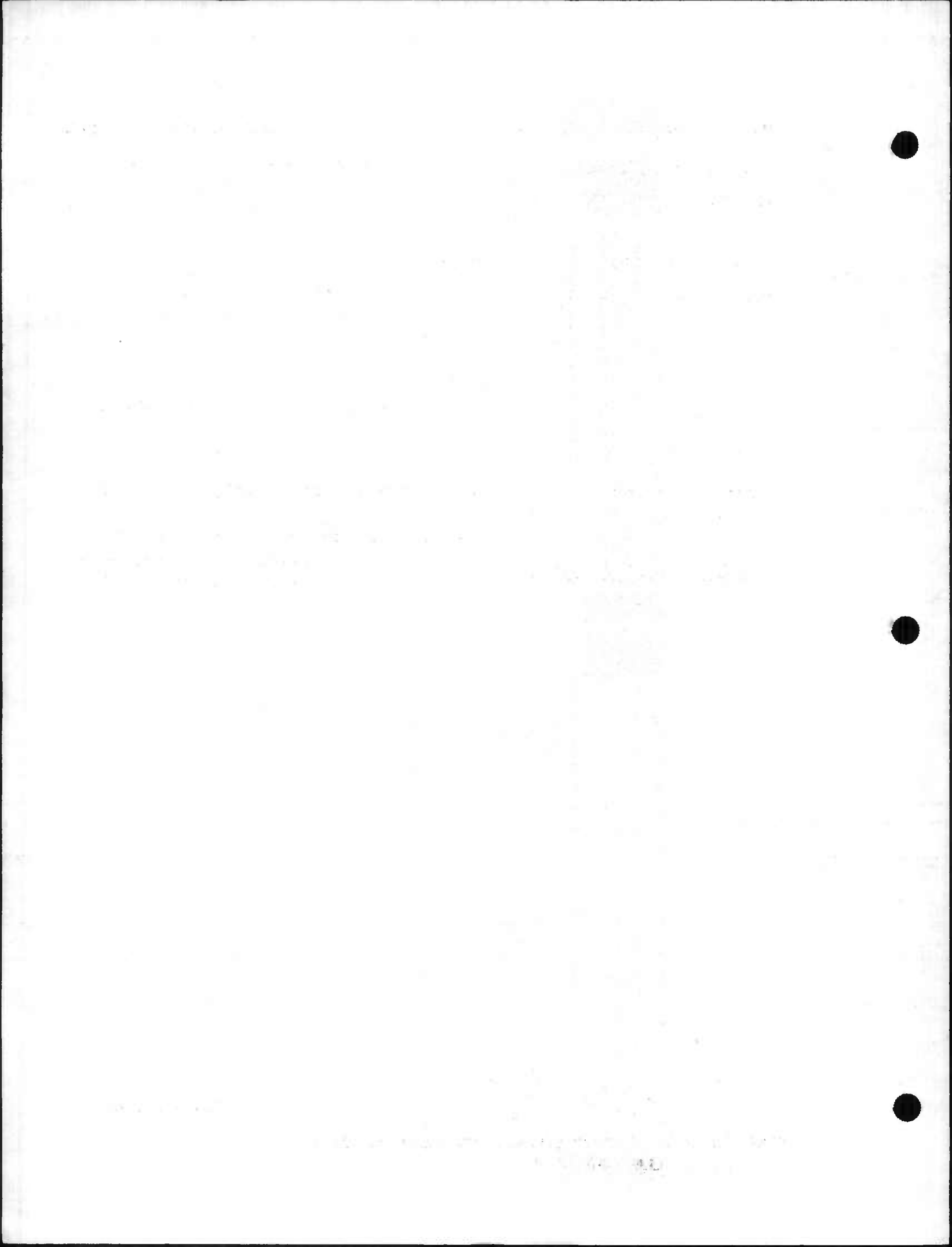
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23441

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) AGNES MARIE LAUGHLIN						2. Date of Death Month Day Year JULY 20, 1996		3. Time of Death 2150	
	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital						4b. City, Town, or Location of Death Cumberland		4c. County of Death Alleg.	
Funeral Director	5. Social Security Number 212-38-5688		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 11, 1914		9. Birthplace (State or Foreign Country) Md.	
	Usual Residence of Decedent									
10a. State Md.		10b. County Alleg.		10c. City, Town or Location Westernport				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 111 Howard St.				10f. Zip Code 21562		10g. Citizen of What Country? USA				
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Teacher			16b. Kind of Business/Industry Education			
17. Father's Name (First, Middle, Last) Charles E. Laughlin						18. Mother's Name (First, Middle, Maiden Surname) Clara McMillen				
19a. Informant's Name/Relationship (Type, Print) Margaret Laffey						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 222 Rock St. Westernport, Md. 21562				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) St. Peter's Cemetery			Date 7-24-96		20c. Location - City or Town, State Westernport, Md.		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Fredlock Funeral Home 31 Jones St. Piedmont, Wv. 26750				
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death)			a. ACUTE PULMONARY EMBOLI						Approximate Interval Between Onset and Death 1 DAY	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last			Due to (or as a consequence of):						b. CONGESTIVE HEART FAILURE	10 DAYS
			Due to (or as a consequence of):						c. SEPSIS	10 DAYS
			Due to (or as a consequence of):						d. ACUTE PERITONITIS	10 DAYS
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 				29c. License number D24951		29d. Date signed (Month, Day, Year) JULY 21, 1996	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) CHANG OH, M.D. 48 TARN TERRACE FROSTBURG MD 21532										
31. Date filed (Month, Day, Year) JUL 24 1996										



96 23442

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) KATHRYN AGNES LEAKINS				2. DATE OF DEATH MONTH DAY YEAR July 16, '96		3. TIME OF DEATH 12:55 P.M.	
4. SOCIAL SECURITY NUMBER 219-01-2023		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 12, 1915	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 840 Francis Scott Key Highway		9b. CITY, TOWN OR LOCATION OF DEATH Keymar	
9c. COUNTY OF DEATH Carroll				10a. STATE Maryland		10b. COUNTY Carroll	
10c. CITY, TOWN OR LOCATION Keymar				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 840 Francis Scott Key Highway	
10f. ZIP CODE 21757				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner & Operator		16b. KIND OF BUSINESS/INDUSTRY L. & S. Antiques	
17. FATHER'S NAME (First, Middle, Last) Millard Hamilton Bostian				18. MOTHER'S NAME (First, Middle, Maiden Surname) Carrie Adelaide Stitley			
19a. INFORMANT'S NAME (Type/Print) Patricia Soper/Daughter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 358 Park Avenue, Frederick, Maryland 21701			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Union Chapel Cemetery 7/20		20c. LOCATION — City or Town, State Libertytown, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. LUNG CANCER WITH BRAIN METASTASES DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 8 months
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Wm. R. Linticum, M.D.				29c. LICENSE NUMBER D14317		29d. DATE SIGNED (Month, Day, Year) 7/16/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WILLIAM R. LINTICUM, M.D. ONE KINGS DRIVE, TANEYTOWN, MD 21787							
31. DATE FILED (Month, Day, Year) JUL 19 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23443

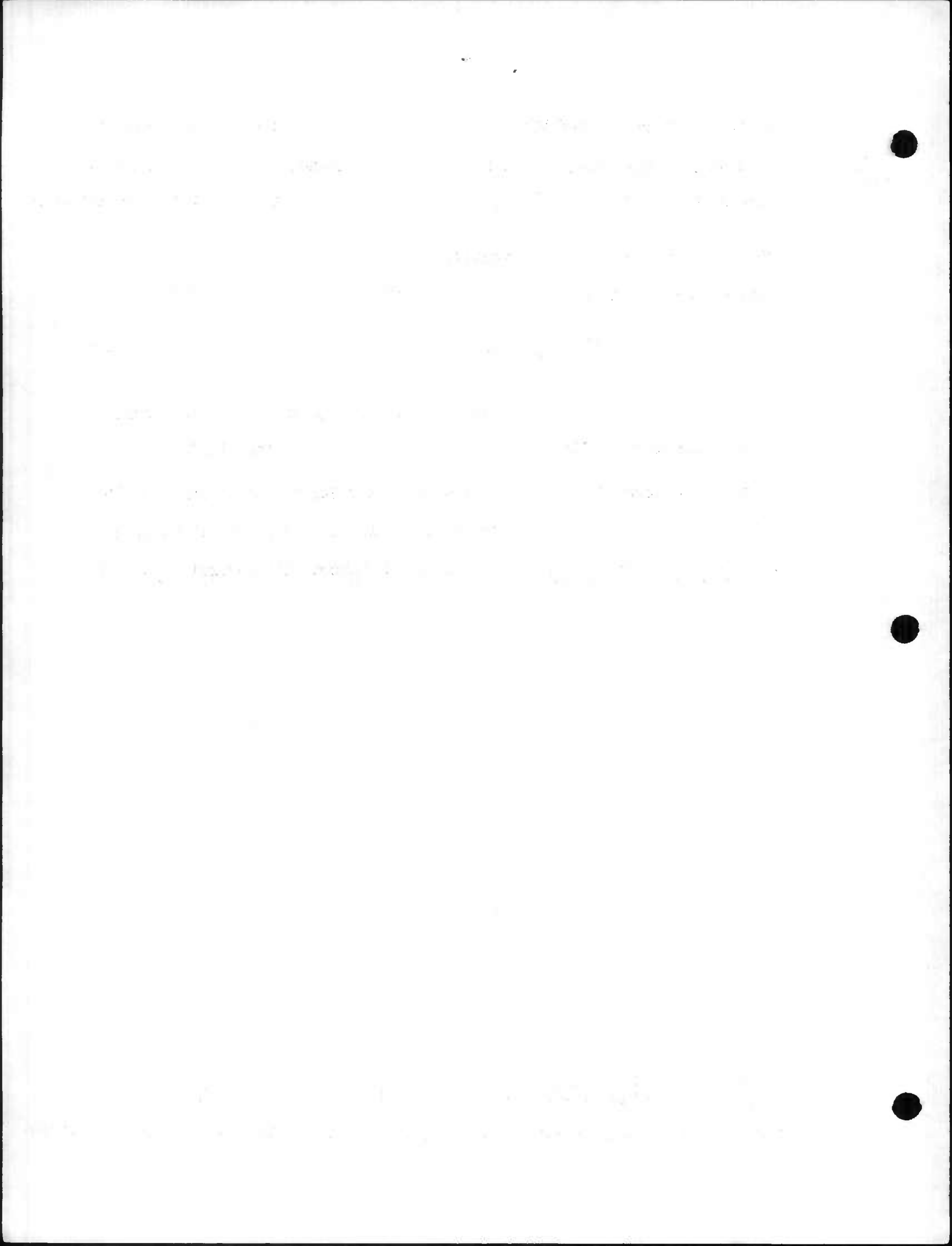
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOSEPH EDWARD MCNULTY				2. Date of Death Month JULY Day 18 Year 1996		3. Time of Death 03:13 AM	
	4a. Facility Name (If not Institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 214-30-4943		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 9, 1933	9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD		10b. County Harford		10c. City, Town or Location Jarrettsville			10d. Inside City Limits 1 Yes 2 No
	10e. Street and Number 4044 St. Clair Bridge Road				10f. Zip Code 21084		10g. Citizen of What Country? USA	
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Korean		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 Collega (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Senior Material Planner			16b. Kind of Business/Industry Electronics	
	17. Father's Name (First, Middle, Last) Joseph Aloysius McNulty				18. Mother's Name (First, Middle, Maiden Sumama) Edith Elizabeth Schuman			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mary C. McNulty/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 4044 St. Clair Bridge Road, Jarrettsville, MD			
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Highview Mem. Gardens		Date 7-22-96		20c. Location - City or Town, State Fallston, MD	
	21. Signature of Funeral Service Licensee <i>Stephen A. Murphy</i>				22. Name and Address of Facility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gastrointestinal hemorrhage Due to (or as a consequence of): b. cirrhosis of liver Due to (or as a consequence of): c. alcoholism Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death 72 hrs
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
25. Was case referred to medical examiner? 1 Yes 2 No				26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)				
27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Thomas F. Lansdale M.D.</i>		29c. License number 043936		29d. Date signed (Month, Day, Year) 7/19/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS F. LANSDALE III, M.D. 6565 N. Charles St., Baltimore, MD 21204								
31. Date filed (Month, Day, Year) JUL 25 1996		32. Registrar's Signature <i>John Anderson-Randall</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23444

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Clarice Muriel McCollough				2. Date of Death Month Day Year July 19, 1996		3. Time of Death 2:05 p.m.	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 142-16-6211		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) Aug. 7, 1924	9. Birthplace (State or Foreign Country) New Jersey
	Usual Residence of Decedent				10a. State Maryland		10b. County Frederick	
To Be Completed by Funeral Director	10c. City, Town or Location Frederick				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 7801 Spout Springs Road	
	10f. Zip Code 21702				10g. Citizen of What Country? U.S.A.		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Antiques Dealer		16b. Kind of Business/Industry Self-employed	
	17. Father's Name (First, Middle, Last) Leonard K. Schimek				18. Mother's Name (First, Middle, Maiden Surname) Pauline Gold			
	19a. Informant's Name/Relationship (Type, Print) Carl A. McCollough/ Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7801 Spout Springs Road, Frederick, MD 21702			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory		20c. Location - City or Town, State 7/20 Smithsburg, Maryland		21. Signature of Funeral Service Licensee 	
	22. Name and Address of Facility Robert E. Dailey & Son Funeral Homes, P.A. 1201 North Market Street, Frederick, MD 21701				23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Probable embolic strokes Due to (or as a consequence of): b. Atherosclerotic Disease (diffuse) Due to (or as a consequence of): c. Diabetes Due to (or as a consequence of): d. Hypertension			
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End Stage Renal Disease				23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how Injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier William H. Johnson M.D.				
29c. License number D47556				29d. Date signed (Month, Day, Year) 7/19/96				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William H. Johnson M.D., 201 Thomas Johnson Drive, MD 21702				31. Data filed (Month, Day, Year) JUL 22 1996				
32. Registrar's Signature 				33. State Registrar 21702				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEMS: 23 PART I, 27, PER MEO FILM State of Maryland / Department of Health and Mental Hygiene

G-738 8/9/96 t.t

96 23445

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHNNY PATRICK McKELLAR JR.

2. Date of Death

Month Day Year
JULY 12, 1996

3. Time of Death

13:50 P

4a. Facility Name (If not institution, give street and number)

1749 HEATHER LANE

4b. City, Town, or Location of Death

FREDERICK

4c. County of Death

FREDERICK

Funeral
Director

5. Social Security Number

217-45-7374

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Oct 27, 1995

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

7029 Allington Manor Circle East

10f. Zip Code

21703

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Johnny Patrick McKellar, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Tracy Hemingway

19a. Informant's Name/Relationship (Type, Print)

Johnny P. McKellar, Sr./Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7029 Allington Manor Cir. Frederick, Maryland 21702

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. Olivet Cemetery

Date

7/18/96

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

P. B. Mackay

22. Name and Address of Facility

Stauffer Funeral Homes, P.A.

1621 Opossumtown Pike, Frederick, MD

21702

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

MYOCARDITIS

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

SITTERS

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
8 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician:2 ☒ Medical Examiner:

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. Dixon

29c. License number

OCME

29d. Date signed (Month, Day, Year)

JULY 13, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 22 1996

32. Registrar's Signature

John Davidson

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

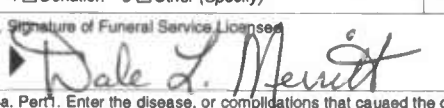
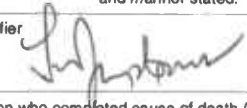
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23446

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THOMAS EUGENE MACKERT				2. Date of Death Month Day Year JULY 20 1996				3. Time of Death 7:40A.M.				
	4a. Facility Name (If not institution, give street and number) 412 HOLLAND STREET				4b. City, Town, or Location of Death CUMBERLAND				4c. County of Death ALLEGANY				
Funeral Director	5. Social Security Number 215-20-5976		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) NOV 10 1925		9. Birthplace (State or Foreign Country) MARYLAND				
	Usual Residence of Decedent												
10a. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 412 HOLLAND STREET				10f. Zip Code 21502				10g. Citizen of What Country? U.S.A.					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) U.S. POSTAL SERVICE				16b. Kind of Business/Industry LETTER CARRIER					
17. Father's Name (First, Middle, Last) JOSEPH ALBERT MACKERT						18. Mother's Name (First, Middle, Maiden Surname) RUTH NAOMI SMITH							
19a. Informant's Name/Relationship (Type, Print) CATHERINE E. MACKERT WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 412 HOLLAND STREET CUMBERLAND MARYLAND 21502									
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) CUMBERLAND CREMATORY				Date JULY 20 1996		20c. Location - City or Town, State CUMBERLAND MARYLAND			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ADVANCED LYMPHOMA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):												Approximate Interval Between Onset and Death 2 YEARS	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier 				29c. License number D 33280				29d. Date signed (Month, Day, Year) July 20, 1996					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. SUNIL K. GUPTA MEMORIAL HOSPITAL CUMBERLAND MARYLAND 21502													
31. Date filed (Month, Day, Year) JUL 22 1996				32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23447

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RUDOLPH NAZELROD				2. Date of Death Month JULY 21 , Day 1996 Year		3. Time of Death 07:45	
	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 213-24-5468		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 23, 1921	9. Birthplace (State or Foreign Country) West Virginia
	Usual Residence of Decedent							
10a. State WV		10b. County Hampshire		10c. City, Town or Location Romney		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number HC 74, Box 56 A		10f. Zip Code 26757		10g. Citizen of What Country? U.S.A.				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A		College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Auto Mechanic		16b. Kind of Business/Industry Garage		
17. Father's Name (First, Middle, Last) Samuel Edward Nazelrod				18. Mother's Name (First, Middle, Maiden Surname) Grace Alice Kesner				
19a. Informant's Name/Relationship (Type, Print) Norma E. Nazelrod Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HC 74, Box 56 A, Romney, WV 26757				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ebenezer Cemetery		Date July 23, 1996		20c. Location - City or Town, State Romney, WV		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Shaffer Funeral Home, Inc. 230 East Main St., Romney, WV 26757				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Squamous Cell Carcinoma of Lung Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								Approximate Interval Between Onset and Death 2 mos
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		28. Piece of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D22181		29d. Date signed (Month, Day, Year) JULY 22, 1996		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Gary L. Wagner, MD, 925 Bishop Walsh Rd, Cumberland, MD 21502								
31. Date filed (Month, Day, Year) JUL 25 1996		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23448

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES J. AKA O'Connor O CONNER		2. Date of Death Month JULY Day 25 Year 1996		3. Time of Death 3:00 PM
	4a. Facility Name (If not institution, give street and number) DORCESTER GENERAL HOSPITAL		4b. City, Town, or Location of Death CAMBRIDGE		4c. County of Death DORCESTER
Funeral Director	5. Social Security Number 219-84-8700	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 31 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) 07/12/65		9. Birthplace (State or Foreign Country) Delaware		
Usual Residence of Decedent					
10a. State MD		10b. County Caroline		10c. City, Town or Location Federalsburg	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 216 Vesper Avenue		10f. Zip Code 21632		10g. Citizen of What Country? Unites States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dispatcher		16b. Kind of Business/Industry Trucking Company	
17. Father's Name (First, Middle, Last) Harry Joseph O'Connor		18. Mother's Name (First, Middle, Maiden Surname) Cora Belle Clevenger			
19a. Informant's Name/Relationship (Type, Print) Cora Belle O'Connor		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 216 Vesper Avenue, Federalsburg, MD 21632			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bloomery Cemetery		20c. Location - City or Town, State 7/29 Federalsburg, MD	
21. Signature of Funeral Service Licensee Michael J. Egan		22. Name and Address of Facility Frampton-Hawkins-Eskow Funeral Home Federalsburg, MD 21632			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Multiple Injuries Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day Year) 7-25-96		28b. Time of Injury 1253 M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Driver in auto free impact	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET		28f. Location (Street and Number or Rural Route Number, City or Town, State) Rte 392 Hurluck	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier J. Laron Locke, MD		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 26, 1996	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Laron Locke, MD 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) JUL 29 '96		32. Registrar's Signature J. Davidson-Randall			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23449

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Wilbert Woodrow OTT				2. Date of Death Month Day Year July 19, 1996		3. Time of Death 4:05 AM																																										
	4a. Facility Name (If not institution, give street and number) 5103 Doubs Road				4b. City, Town, or Location of Death Adamstown		4c. County of Death Frederick																																										
Funeral Director	5. Social Security Number 232-09-5595	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 28, 1918		9. Birthplace (State or Foreign Country) West Virginia																																									
	Usual Residence of Decedent																																																
To Be Completed by Funeral Director	10a. State Maryland	10b. County Frederick	10c. City, Town or Location Adamstown			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																											
	10e. Street and Number 5103 Doubs Road			10f. Zip Code 21710		10g. Citizen of What Country? U.S.A.																																											
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White																																										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Custodian			16b. Kind of Business/Industry Board of Education																																											
	17. Father's Name (First, Middle, Last) Thomas Newton OTT				18. Mother's Name (First, Middle, Maiden Surname) Berttie MEDLAR																																												
	19a. Informant's Name/Relationship (Type, Print) Mrs. Evelyn G. Ott, Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5103 Doubs Road, Adamstown, Maryland 21710																																												
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Memorial Gardens, July 22, 1996		20c. Location - City or Town, State Frederick, Maryland																																												
	21. Signature of Funeral Service Licensee Richard E. [Signature] M00255		22. Name and Address of Facility Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701																																														
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																																
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="6">e. Small cell carcinoma of the lung</td> <td rowspan="4">Approximate Interval Between Onset and Death 2 years</td> </tr> <tr> <td colspan="6">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="6">b. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="6">c. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="8">Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> </tr> <tr> <td colspan="8">d. Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	e. Small cell carcinoma of the lung						Approximate Interval Between Onset and Death 2 years	Due to (or as a consequence of):						b. Due to (or as a consequence of):						c. Due to (or as a consequence of):						Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								d. Due to (or as a consequence of):						
Immediate Cause (Final disease or condition resulting in death)	e. Small cell carcinoma of the lung						Approximate Interval Between Onset and Death 2 years																																										
	Due to (or as a consequence of):																																																
	b. Due to (or as a consequence of):																																																
	c. Due to (or as a consequence of):																																																
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last																																																	
d. Due to (or as a consequence of):																																																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Squamous cell carcinoma of pharynx																																																	
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																																																	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																																	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																																	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)																																															
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred																																									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Kathleen W. Stern MD		29c. License number D 32073		29d. Date signed (Month, Day, Year) July 19, 1996																																											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Kathleen W. Stern MD 610 Ninth Avenue, Brunswick, Maryland 21716																																																	
31. Date filed (Month, Day, Year) JUL 22 1996		32. Registrar's Signature John [Signature]																																															

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23450

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET M. PEIRSON

2. Date of Death

JULY 25 1996 8:30A

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Lorien Nursing Home

4b. City, Town, or Location of Death

BELCAMP

4c. County of Death

Harford

5. Social Security Number

169-20-8408

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 8, 1921

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

-

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

21 Right Aileron Street

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

House wife

16b. Kind of Business/Industry

In Home

17. Father's Name (First, Middle, Last)

James Howard Casselberry

18. Mother's Name (First, Middle, Maiden Surname)

Hannah Isabel Brownell

19a. Informant's Name/Relationship (Type, Print)

Mrs. Nellie I. Pugh (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21 Right Aileron Street, Baltimore, MD 21220

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Mem. Gardens

Date

7/29

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Broken Amy Unglesbee

22. Name and Address of Facility

Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebro Vascular Accident

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 months

10 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☒ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William MD.

29c. License number

D 32609.

29d. Date signed (Month, Day, Year)

7/25/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Kamudin Mitham MD. 703 Revolution St Havre De Grace MD 21078.

State
Registrar

31. Date filed (Month, Day, Year)

JUL 25 1996

32. Registrar's Signature

Johanna Anderson Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

96-4087-025

ITEMS: 23 PART I, 27, 28a-f,

PER MEO FILM G-738 8/9/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23451

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MICHAEL JOSEPH PAYNE SR.		2. Date of Death Month JULY Day 22 Year 1996		3. Time of Death 12:40 P.M.
	4e. Facility Name (If not Institution, give street and number) 143 N. LYNBROOK ROAD		4b. City, Town, or Location of Death BELAIR		4c. County of Death HARFORD COUNTY
Funeral Director	5. Social Security Number 215-74-4767	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 38 Yrs.	If Under 1 Year Months 0 Days 0	If Under 24 Hrs. Hours 0 Min. 0
	8. Date of Birth (Month, Day, Year) Dec. 3, 1957		9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State Maryland	10b. County Harford	10c. City, Town or Location Bel Air		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 143 North Lynbrook Road		10f. Zip Code 21014		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mail Handler		16b. Kind of Business/Industry U.S. Postal Service		
	17. Father's Name (First, Middle, Last) Charles Nathaniel Payne		18. Mother's Name (First, Middle, Maiden Surname) Mary Bernadette Kotmair		
	19a. Informant's Name/Relationship (Type, Print) Peggy A. Payne - Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 143 N. Lynbrook Rd., Bel Air, Md. 21014		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Cemetery		20c. Location - City or Town, State Owings Mill, Md.
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009		
Physician /Medical Examiner	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
	Immediate Cause (Final disease or condition resulting in death) MIXED DRUG INTOXICATION				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
	24e. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) FOUND 7-22-96		28b. Time of Injury 10:40 AM	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred UNKNOWN		28f. Location (Street and Number or Rural Route Number, City or Town, State) 143 N. LYNBROOK ROAD BEL AIR, MARYLAND	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME					
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 23, 1996	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DONALD G. WRIGHT M.D. 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) JUL 25 1996		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23452

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anthony Parham				2. Date of Death Month July Day 20 Year 1996		3. Time of Death 5:15 PM	
	4a. Facility Name (If not institution, give street and number) The Kent & Queen Anne's Hospital				4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent	
Funeral Director	5. Social Security Number 213-68-3278		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 38 Yrs.		8. Date of Birth (Month, Day, Year) Mar. 10, 1958	
	9. Birthplace (State or Foreign Country) South Carolina		10a. State Maryland		10b. County Kent		10c. City, Town or Location Chestertown	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 160 Flatland Road Apt. 119		10f. Zip Code 21620		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1979		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Trucking Company			
	17. Father's Name (First, Middle, Last) James Curtis Parham, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Margaret Jean Testerman			
	19a. Informant's Name/Relationship (Type, Print) Margaret J. Rakes (mother)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 West Inca Street, Aberdeen, Maryland 21001			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harford Memorial Gardens		20c. Location - City or Town, State Aberdeen, Maryland		20d. Date 7/24/96	
	21. Signature of Funeral Service Licensee Bursten Amy Unglesbee				22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. ACUTE MASSIVE MI Due to (or as a consequence of): b. HTN Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 hour UNKNOWN							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. prob 9 cholesterol							
	23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier [Signature]				29c. License number D36054		29d. Date signed (Month, Day, Year) 7/20/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 120 SPEER Rd, Chestertown Md 21620								
31. Date filed (Month, Day, Year) JUL 21 1996								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

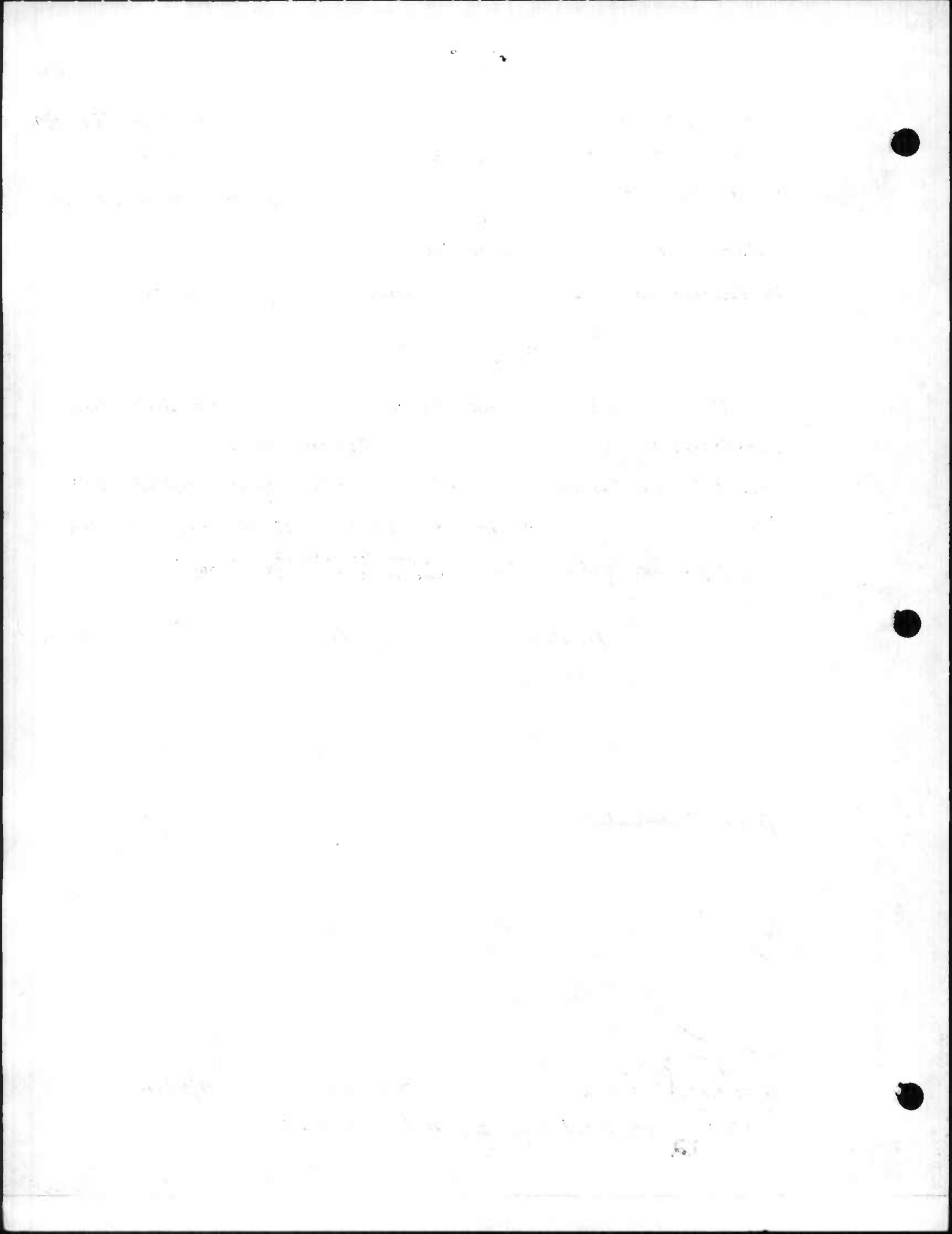
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23453

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert William Pearson						2. Date of Death Month 7 Day 18 Year 1996		3. Time of Death 2:40 pm	
	4a. Facility Name (If not institution, give street and number) 8771 Treasure Ave.						4b. City, Town, or Location of Death Walkersville		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 338-61-0905		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 1, 1916		9. Birthplace (State or Foreign Country) Illinois	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Walkersville				10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 8771 Treasure Ave.				10f. Zip Code 21793		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry U.S. Government			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Axel Syvanis Pearson						18. Mother's Name (First, Middle, Maiden Surname) Ida Peterson Pearson			
	19a. Informant's Name/Relationship (Type, Print) Nancy Pearson, wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8771 Treasure Ave., Walkersville, MD 21793			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory		20c. Location - City or Town, State Hagerstown, MD		20d. Date 7/20/1996			
	21. Signature of Funeral Service Licensee Thom M. Burger		22. Name and Address of Facility Stauffer Funeral Home		22b. Address of Facility 1621 Opossumtown Pk. Frederick, MD 21702		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Stroke Due to (or as a consequence of): ischemic heart Due to (or as a consequence of): hypertension Due to (or as a consequence of): 3 days years years			
23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Thom M. Burger		29c. License number D22101		29d. Date signed (Month, Day, Year) 7/19/96				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wladyslaw Hylunson 1475 King Ave Frederick MD 21701										
31. Date filed (Month, Day, Year) JUL 24 1996		32. Registrar's Signature John Davidson-Barclay								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 23454

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HARRIET MARIE PRESTON

2. Date of Death

Month
JULYDay
23Year
1996

3. Time of Death

07:10 A

4a. Facility Name (If not institution, give street and number)

SACRED HEART HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral
Director

5. Social Security Number

236-04-3914

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JUNE 16 1916

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

PINTO

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

ROUTE 220

10f. Zip Code

21556

10g. Citizen of What Country?

U S A

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

18a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

ADAM HISE

18. Mother's Name (First, Middle, Maiden Surname)

ALICE M. BARNES

19a. Informant's Name/Relationship (Type, Print)

DOROTHY L. PRESTON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

POTOMAC HOLLOW ROAD BARTON, MARYLAND 21521

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LAUREL HILL CEMETERY

Date

7/26

20c. Location - City or Town, State

BARTON, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HAFFER CHAPEL OF THE HILLS MORTUARY
1302 NATIONAL HWY LAVALE, MARYLAND 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Renal Failure

Due to (or as a consequence of):

2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertensive Kidney Disease

Due to (or as a consequence of):

6 months

c. Hypertension

Due to (or as a consequence of):

25 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sepsis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

R. Fadd

29c. License number

16150

29d. Date signed (Month, Day, Year)

JULY 23, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ragaa Fadd, M.D., 921 Seton Drive #F, Cumberland, MD 21502

31. Date filed (Month, Day, Year)

JUL 29 1996

32. Registrar's Signature

John Anderson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 902A.

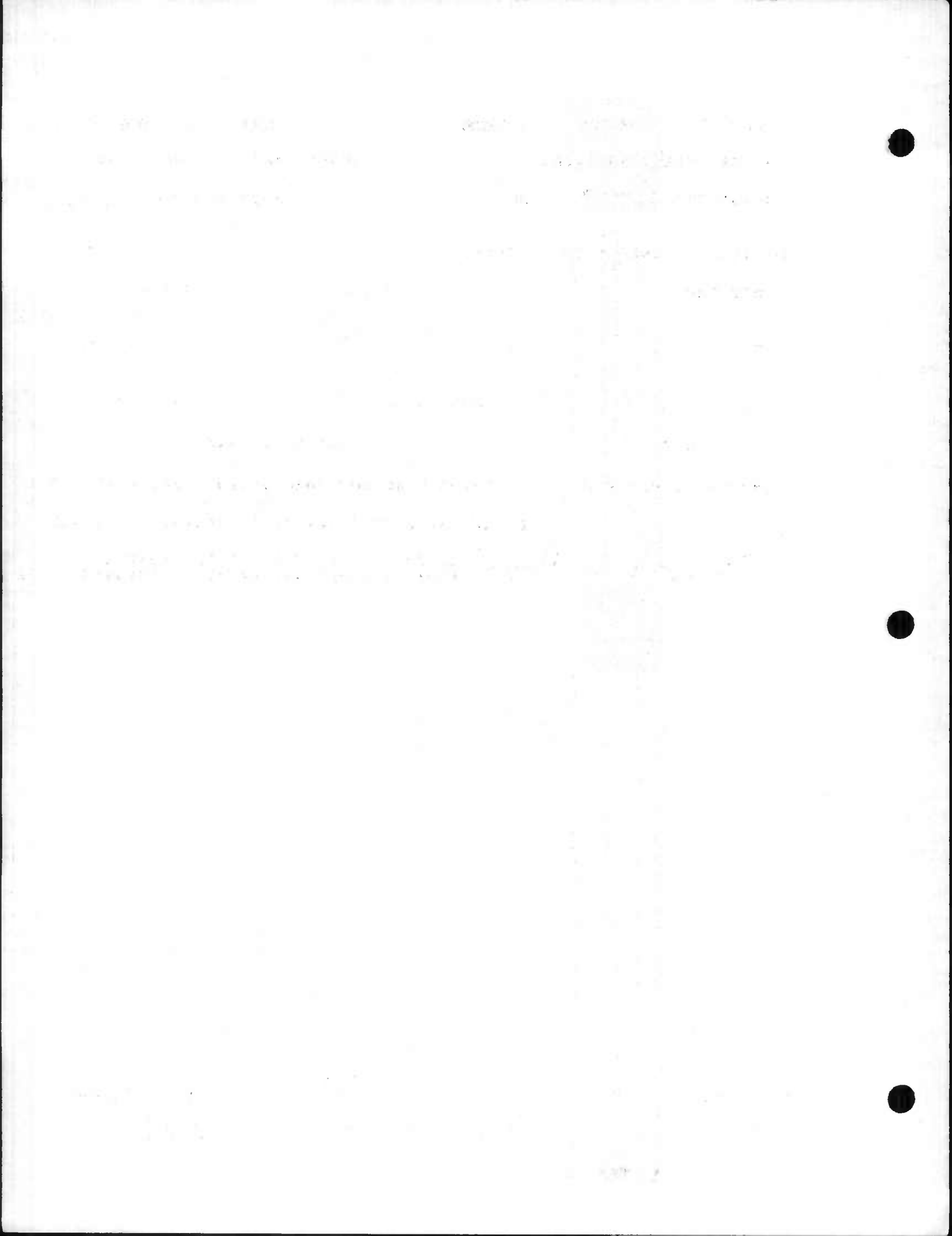
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director




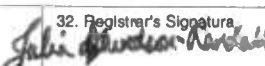
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23455

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIS E. POLING				2. Date of Death Month JULY Day 22 Year 1996		3. Time of Death 0121	
	4a. Facility Name (If not Institution, give street and number) Memorial Hospital				4b. City, Town, or Location of Death CUMBERLAND, MD		4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 232-22-3123		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) August 9 1914	
	9. Birthplace (State or Foreign Country) West Virginia		10a. State WV		10b. County Hampshire		10c. City, Town or Location Springfield	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number P.O. Box 119		10f. Zip Code 26763		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Unknown		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Employee Shipyard		16b. Kind of Business/Industry Shipbuilding				
17. Father's Name (First, Middle, Last) Jonas Poling		18. Mother's Name (First, Middle, Maiden Surname) Blanche Bowman		19a. Informant's Name/Relationship (Type, Print) Jean Fuller - Sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24015 Bartlett Run Rd. Barton, Md. 21521		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cumberland Crematory		20c. Location - City or Town, State 7-23-96 Cumberland, Md.				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Boal Funeral Home 111 Church St. Westernport, Md.						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HTLV		Approximate Interval Between Onset and Death 2 years 8 years						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		
28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D36766		29d. Date signed (Month, Day, Year) 7/23/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. VIK POONAI 955 FREDERICK STREET CUMBERLAND, MD 21502		31. Date filed (Month, Day, Year) JUL 24 1996		32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

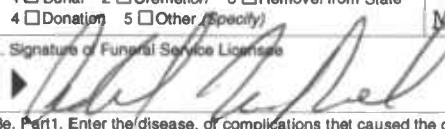
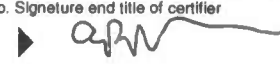
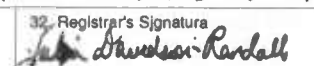
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23456

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GARNIE RELIFORD				2. Date of Death Month Day Year JULY 23, 1996		3. Time of Death 00:40 AM	
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death	
Funeral Director	5. Social Security Number 263-48-6581	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 10, 1930		9. Birthplace (State or Foreign Country) GA
	Usual Residence of Decedent							
10a. State MD		10b. County Harford		10c. City, Town or Location Aberdeen			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 105 Hanover St.				10f. Zip Code 21001		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) cook		16b. Kind of Business/Industry restaurant		
17. Father's Name (First, Middle, Last) Coy Reliford				18. Mother's Name (First, Middle, Maiden Surname) Cleotha Nelson				
19a. Informant's Name/Relationship (Type, Print) Leslie Barton				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1240 Battery Dr. Havre de Grace, MD 21078				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. Calvary Cem.		Date 7-96		20c. Location - City or Town, State Aberdeen, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Beard Funeral Home 552 Lewis St. Havre de Grace, MD				
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aortic Regurgitation Due to (or as a consequence of): ENDOCARDITIS Due to (or as a consequence of): END-STAGE RENAL DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HYPERTENSION CORONARY ARTERY DISEASE								Approximate Interval Between Onset and Death THREE WEEKS THREE WEEKS SEVEN YEARS
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION CORONARY ARTERY DISEASE						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  M.D.		29c. License number m6260		29d. Date signed (Month, Day, Year) July 23, 1996		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ERIC HAURA JOHNS HOPKINS HOSPITAL BALTIMORE, MARYLAND								
31. Date filed (Month, Day, Year) JUL 25 1996		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 23457

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William Elwood Radcliffe				2. DATE OF DEATH MONTH DAY YEAR July 27 1996				3. TIME OF DEATH 8:35 a m							
4. SOCIAL SECURITY NUMBER 218-03-0384		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Aug. 19, 1917		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) Chestertown Nursing & Rehab Center						9b. CITY, TOWN OR LOCATION OF DEATH Chestertown				9c. COUNTY OF DEATH Kent					
RESIDENCE OF DECEDENT															
10a. STATE Maryland				10b. COUNTY Caroline				10c. CITY, TOWN OR LOCATION Henderson				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 16840 #16 Henderson Road						10f. ZIP CODE 21640				10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11-grad						16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) guard				16b. KIND OF BUSINESS/INDUSTRY MD Correctional Institution					
17. FATHER'S NAME (First, Middle, Last) Rufus Radcliffe						18. MOTHER'S NAME (First, Middle, Maiden Surname) Evelyn M. Lewis Radcliffe									
19a. INFORMANT'S NAME (Type/Print) Ruth Anna Dawkins						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16840 Henderson Road, Henderson, MD 21640									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)						20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greensboro Cemetery 7/30				20c. LOCATION — City or Town, State Greensboro, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY Fleegle-Helfenbein Funeral Home P.O. Box 160 Greensboro, MD 21639									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>glioblastoma multiform</u> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>laryngeal cancer</u> <u>lung cancer</u>															
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER 033514				29d. DATE SIGNED (Month, Day, Year) 7-29-96					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael Brenenfeld MD 100 Brown St. Chestertown, Md. 21620															
31. DATE FILED (Month, Day, Year) Jul 30 '96				32. REGISTRAR'S SIGNATURE 											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23458

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES MORGAN RODGERS				2. Date of Death Month Day Year JULY 20, 1996		3. Time of Death 9:50PM		
	4a. Facility Name (If not institution, give street and number) 23956 Willow Pond Road				4b. City, Town, or Location of Death Denton		4c. County of Death Caroline		
Funeral Director	5. Social Security Number 219-40-5539		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 51 Yrs.		8. Date of Birth (Month, Day, Year) 09/25/44		
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Caroline		10c. City, Town or Location Denton		
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 23956 Willow Pond Road		10f. Zip Code 21629		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) Collage		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic		16b. Kind of Business/Industry Automotive (Ford)				
	17. Father's Name (First, Middle, Last) Carl F. Rodgers				18. Mother's Name (First, Middle, Maiden Surname) Althea Donaldson				
	19a. Informant's Name/Relationship (Type, Print) Myrna J. Rodgers				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23956 Willow Road, Denton, MD 21629				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Denton Cemetery		20c. Location - City or Town, State 7/25 Denton, Maryland				
	21. Signature of Funeral Service Licensee Micheal F. Eskow				22. Name and Address of Facility Frampton-Hawkins-Eskow Funeral Home PO Box 43, Federalsburg, MD 21632				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. cardiorespiratory arrest Due to (or as a consequence of): b. metastatic prostate cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 year								
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
			28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)				
			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
State Registrar	29b. Signature and title of certifier John P. Mastandrea				29c. License number D36644		29d. Date signed (Month, Day, Year) 7-23-96		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN P. MASTANDREA 509 IDEWILDS AVE, EASTON, MD, 21601								
31. Date filed (Month, Day, Year) JUL 25 1996				32. Registrar's Signature Julia Davidson-Randall				32. Registrar's Signature JUL 25 '96	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

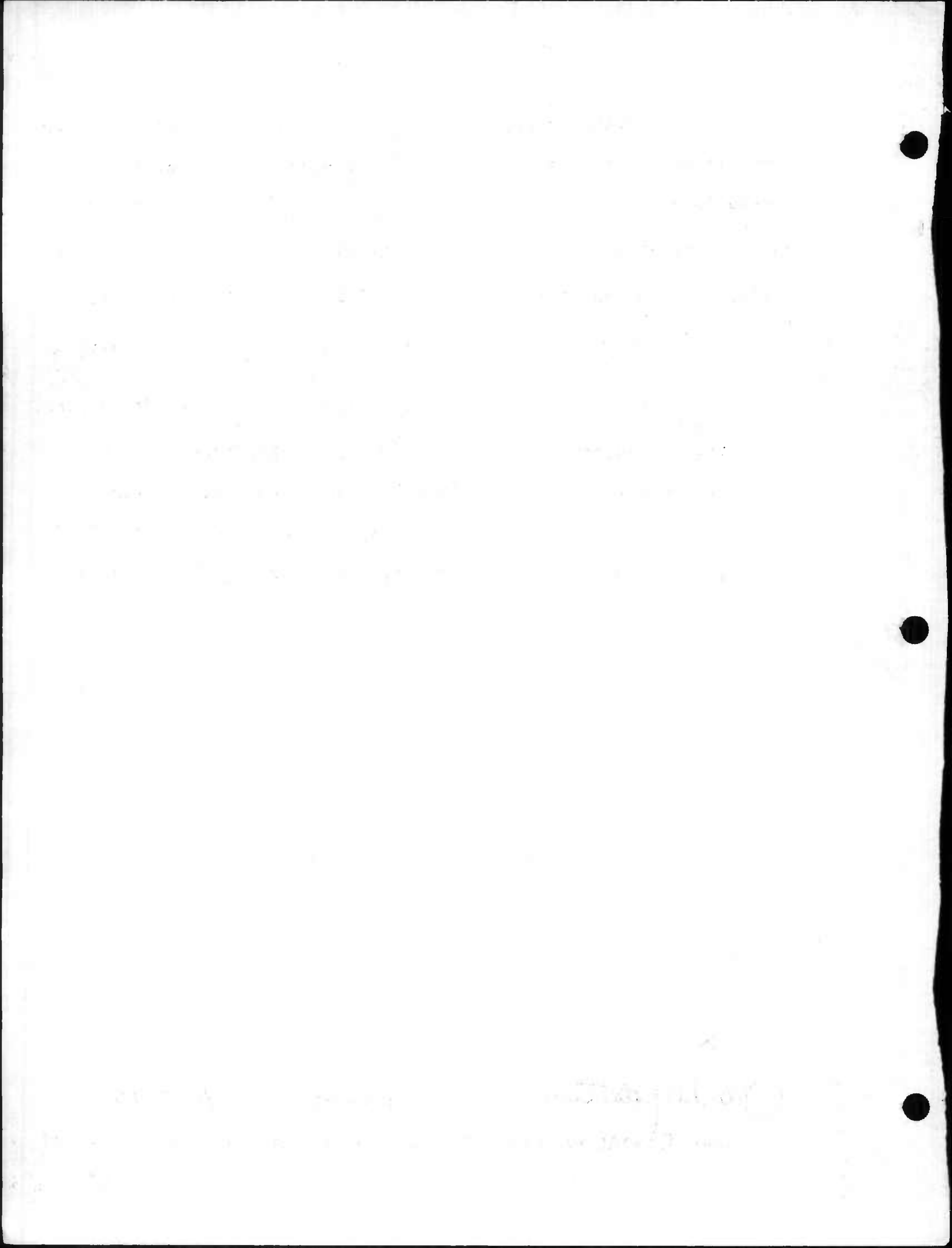
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Amended Line 8
FCHD, JO

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23459

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy Dix REDMOND				2. Date of Death Month Day Year July 22, 1996		3. Time of Death 10:45 P.M.	
	4a. Facility Name (If not Institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 220-09-5496		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) April 25, 1906	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 8052 Ball Road		10f. Zip Code 21704		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) George Randolph Crummitt	
	18. Mother's Name (First, Middle, Maiden Summa) Mary Elizabeth Hanson		19a. Informant's Name/Relationship (Type, Print) Mary Elizabeth Stup		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8052 Ball Road, Frederick, Md. 21704		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery		20c. Location - City or Town, State Frederick, Maryland		21. Signature of Funeral Service Licensee Richard C.C. Basford M00021		22. Name and Address of Facility Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Renal Failure Due to (or as a consequence of): b. Pneumonia Due to (or as a consequence of): c. Congestive Heart Failure Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Timothy F. Hickey, M.D.		29c. License number D01711		29d. Date signed (Month, Day, Year) July 23, 1996	
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Timothy F. Hickey, M.D., 801 Toll House Ave., Frederick, Maryland 21701		31. Date filed (Month, Day, Year) JUL 24 1996		32. Registrar's Signature John A. Hickey		33. Date of filing (Month, Day, Year)	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23460

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Helen Miller Rudy				2. Date of Death Month July Day 17 Year 1996		3. Time of Death 9:30 AM	
	4a. Facility Name (If not institution, give street and number) Homewood Retirement Center				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 214-10-2655		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 2, 1917	9. Birthplace (State or Foreign Country) Md.
	Usual Residence of Decedent							
10a. State Md.		10b. County Frederick		10c. City, Town or Location Middletown			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 213 Broad St.				10f. Zip Code 21769		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 Collegia (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker			16b. Kind of Business/Industry own home	
17. Father's Name (First, Middle, Last) John P. Miller				18. Mother's Name (First, Middle, Maiden Surname) Rebecca Pomeroy				
19a. Informant's Name/Relationship (Type, Print) John J. Rudy				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 334 S. Jefferson St., Middletown, Md. 21769				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Lutheran Cemetery		Date 7/20		20c. Location - City or Town, State Middletown, Md.	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. 21769				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. CVA - Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death 3 Wks
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number 1013971		29d. Date signed (Month, Day, Year) 7/23/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert L. Kaufmann, MD, 300 N. 9th St., Fred., MD 21701								
31. Date filed (Month, Day, Year) JUL 24 1996		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Amended #5, 7/29/96
PAK, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 23461

Reg. No.

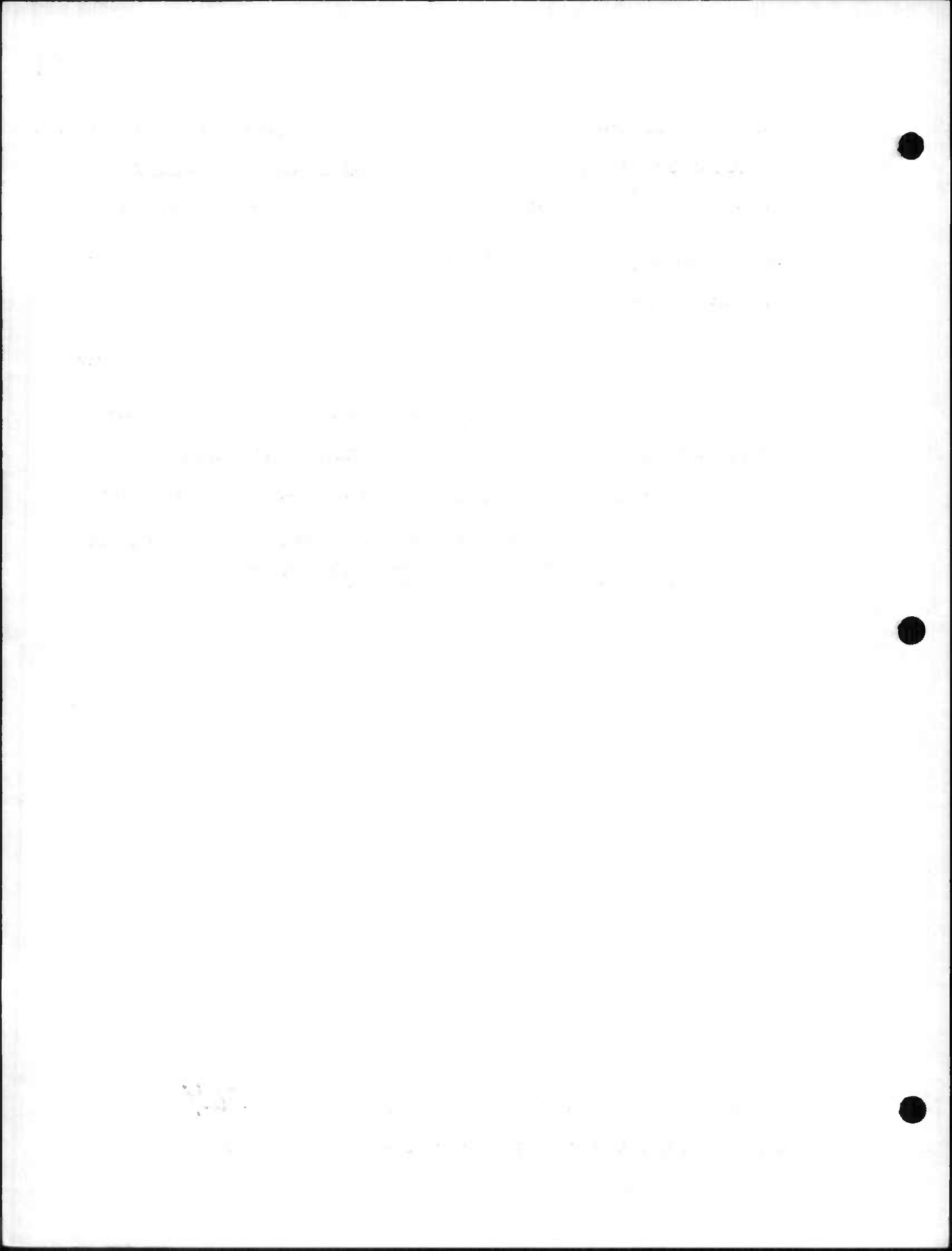
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LEROY ROBERTSON		2. Date of Death Month JULY Day 26 Year 1996		3. Time of Death 10:20 AM
	4a. Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL		4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY
Funeral Director	5. Social Security Number 220-10-7511	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Jul 15, 1921		9. Birthplace (State or Foreign Country) MD		
To Be Completed by Funeral Director	10a. State MD		10b. County Allegany		10c. City, Town or Location Mt. Savage
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number P.O. Box 572 Apt. 3		10f. Zip Code 21545		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: white				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retired Maintenance		16b. Kind of Business/Industry Tire Company
	17. Father's Name (First, Middle, Last) Rolley Robertson		18. Mother's Name (First, Middle, Maiden Surname) Annie Pearl (Layton)		
	19a. Informant's Name/Relationship (Type, Print) Ethel H. Robertson--wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 572 Apt. 3; Mt. Savage, MD 21545		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Savage UME Church Cem		20c. Location - City or Town, State MD
	21. Signature of Funeral Service Licensee <i>Michael J. Scarpelli</i>		22. Name and Address of Facility Scarpelli Funeral Home Cumberland, MD 21502		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <i>Chronic Cardiomyopathy</i> Due to (or as a consequence of) b. <i>Arteriosclerotic Cardiovascular Disease</i> Due to (or as a consequence of) c. _____ Due to (or as a consequence of) d. _____				Approximate Interval Between Onset and Death <i>4 yrs</i> <i>14 yrs</i>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Obstructive Pulmonary Disease</i>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
State Registrar	29b. Signature and title of certifier <i>Wayne C. Spiggle</i>		29c. License number D11443		29d. Date signed (Month, Day, Year) JULY-26-96
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WAYNE SPIGGLE, M.D. BMG 912 SETON DRIVE CUMBERLAND, MD 21502				
	31. Date filed (Month, Day, Year) JUL 29 1996		32. Registrar's Signature <i>John H. ...</i>		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23462

Certificate of Death

Reg. No.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) RUTH RAYNOR		2. Date of Death Month JULY Day 21 Year 96		3. Time of Death 10:28 P.M.	
4a. Facility Name (If not institution, give street and number) Mercy Medical Center		4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
5. Social Security Number 234-48-3254		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.	
8. Date of Birth May 2, 1931		9. Birthplace (State or Foreign Country) W.V.			
Usual Residence of Decedent					
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 101 Center Place		10f. Zip Code 21222		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker	
16b. Kind of Business/Industry Home		17. Father's Name (First, Middle, Last) Edgar Funkhouser		18. Mother's Name (First, Middle, Maiden Surname) Maysel Kesner	
19a. Informant's Name/Relationship (Type, Print) James Shingler-son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19817 Big Lane, Midland, Md. 21542			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Laurel Hill Cemetery		20c. Location - City or Town, State July 24, 1996 Moscow Mills, Md.	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Eichhorn-McKenzie Funeral Home Lonaconing, Md. 21539			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. RECTAL CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					Approximate Interval Between Onset and Death 3 YEARS
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) STELLA MARIS AT MERCY Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	
28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D40480		29d. Date signed (Month, Day, Year) July 22, 1996	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) FERNANDO J. FERRERO, MD BALTO, MD 21206		31. Date filed (Month, Day, Year) JUL 24 1996			
32. Registrar's Signature 					

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23463

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carl Webster SNOOK				2. Date of Death Month Day Year July 23, 1996		3. Time of Death 1:30 am						
	4a. Facility Name (If not institution, give street and number) Homewood Retirement Center				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick						
Funeral Director	5. Social Security Number 214-10-5210		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 96 Yrs.		8. Date of Birth (Month, Day, Year) Sep 3, 1899						
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick						
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
	10e. Street and Number 31 West Patrick Street				10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.						
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Road Builder		16b. Kind of Business/Industry Construction								
	17. Father's Name (First, Middle, Last) John Wesley SNOOK				18. Mother's Name (First, Middle, Maiden Surname) Florence Alma EYLER								
	19a. Informant's Name/Relationship (Type, Print) Prudence Owen/ P.O.A.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 East Patrick Street, Frederick, MD 21701								
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt Olivet Cemetery		Date Jul 26, 1996		20c. Location - City or Town, State Frederick, Maryland						
	21. Signature of Funeral Service Licensee Keith Lynn Blevins MO0706				22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>e. <u>CVA</u> Due to (or as a consequence of):</td> <td rowspan="4"> Approximate Interval Between Onset and Death <u>1 mo.</u> </td> </tr> <tr> <td>b. _____ Due to (or as a consequence of):</td> </tr> <tr> <td>c. _____ Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____ Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e. <u>CVA</u> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <u>1 mo.</u>	b. _____ Due to (or as a consequence of):	c. _____ Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e. <u>CVA</u> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <u>1 mo.</u>											
	b. _____ Due to (or as a consequence of):												
	c. _____ Due to (or as a consequence of):												
	d. _____ Due to (or as a consequence of):												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown													
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. Signature and title of certifier Robert L. Kaufmann, M.D.				29c. License number D13971		29d. Date signed (Month, Day, Year) July 23, 1996							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert L. Kaufmann, M.D., 300 West Ninth Street, Frederick, Maryland 21701													
31. Date filed (Month, Day, Year) JUL 24 1996				32. Registrar's Signature Lisa Davidson-Roth									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23464

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THEODORE LEONHARD SEMLER				2. Date of Death Month Day Year JULY 22, 1996		3. Time of Death 9:00 AM	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 214-10-2324		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct 30, 1901	9. Birthplace (State or Foreign Country) Germany
	Usual Residence of Decedent							
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 990 Waterford Drive				10f. Zip Code 21702		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chef			16b. Kind of Business/Industry Food Preparation	
17. Father's Name (First, Middle, Last) Leopold SEMMLER				18. Mother's Name (First, Middle, Maiden Surname) Anna SEMMLER				
19a. Informant's Name/Relationship (Type, Print) Mr. Richard Cardwell/P.O.A.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 918 Artie Drive, Lebanon, Tennessee 37090				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mt Olivet Cemetery Jul 24, 1996		20c. Location - City or Town, State Frederick, Maryland		
21. Signature of Funeral Service Licensee <i>Keith Lynn Roberson</i> MOD706				22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 E Church Street, Frederick, Maryland 21701				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Urosepsis</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <i>3 days</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Right pleural effusion, severe osteoarthritis</i> <i>Chronic anemia</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Al J. AFB</i>		29c. License number D35183		29d. Date signed (Month, Day, Year) 7/22/96				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Al J. AFB</i> 300 W 9th St Frederick, MD 21701								
31. Date filed (Month, Day, Year) JUL 24 1996		32. Registrar's Signature <i>John Shuckler</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23465

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edward KENNETH SIMMERS				2. Date of Death Month JULY Day 15 Year 1996		3. Time of Death 22:00	
	4e. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death	
Funeral Director	5. Social Security Number 213-45-7931		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 11 Months 12 Days 12		8. Date of Birth (Month, Day, Year) Aug. 3, 1995	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Thurmont	
To Be Completed by Funeral Director	10e. Street and Number 6539 Fish Hatchery Road				10f. Zip Code 21788		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Infant/ Never Worked		16b. Kind of Business/Industry	
	17. Father's Name (First, Middle, Last) Kenneth Eugene SIMMER, JR.				18. Mother's Name (First, Middle, Maiden Surname) Gabrielle Mae MOSSBURG			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Kenneth E. Simmers, Jr., Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6539 Fish Hatchery Road, Thurmont, Md. 21788			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery, July 18, 1996		20c. Location - City or Town, State Frederick, Maryland		21. Signature of Funeral Service Licensee Richard E. Hraf M00255	
To Be Completed by Physician/Medical Examiner	22. Name and Address of Facility Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701				23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGENITAL HEART DISEASE Due to (or as a consequence of): b. RENAL FAILURE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day Year)				28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
	29b. Signature and title of certifier YONCA BULUT MD				29c. License number M 5604		29d. Date signed (Month, Day, Year) JULY 15 1996	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YONCA BULUT MD, THE JOHNS HOPKINS HOSPITAL, BALTIMORE, MD				31. Date filed (Month, Day, Year) JUL 18 1996			
	32. Registrar's Signature [Signature]				33. Date of Death (Month, Day, Year) JULY 15 1996			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 23466**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALMETA EDITH SUMMERS				2. Date of Death Month JULY Day 21 Year 1996		3. Time of Death 0200						
	4a. Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL				4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY						
Funeral Director	5. Social Security Number 214-07-2229		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JULY 17 1905	9. Birthplace (State or Foreign Country) MARYLAND					
	Usual Residence of Decedent												
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location FROSTBURG		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	10e. Street and Number 18641 CHERRY LANE				10f. Zip Code 21532		10g. Citizen of What Country? U.S.A.						
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: WHITE		14. Race - American Indian, Black, White, etc. Specify: WHITE						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER		16b. Kind of Business/Industry TEXTILES								
	17. Father's Name (First, Middle, Last) JAMES STARKEY				18. Mother's Name (First, Middle, Maiden Surname) IDA TWIGG								
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) IDA M. DAVIS / DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10909 WELSH HILL ROAD S.W. FROSTBURG, MD. 21532								
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) FBG. MEMORIAL PARK		Data JULY 23, 1996		20c. Location - City or Town, State FROSTBURG, MARYLAND						
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility DURST FUNERAL HOME P.A. 57 FROST AVENUE FROSTBURG, MARYLAND 21532								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. HYPERTENSION Due to (or as a consequence of): c. DIABETES MELLITUS Due to (or as a consequence of): d. </td> <td>1 DAY</td> </tr> <tr> <td>30 YEARS</td> </tr> <tr> <td>30 YEARS</td> </tr> <tr> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. HYPERTENSION Due to (or as a consequence of): c. DIABETES MELLITUS Due to (or as a consequence of): d.	1 DAY	30 YEARS	30 YEARS	
	Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. HYPERTENSION Due to (or as a consequence of): c. DIABETES MELLITUS Due to (or as a consequence of): d.	1 DAY											
30 YEARS													
30 YEARS													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ACUTE INTESTINAL BLEEDING AORTIC STENOSIS													
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D24951		29d. Date signed (Month, Day, Year) July 21, 96							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANG OH, M.D. 48 TARN TERRACE FROSTBURG MD 21532													
31. Date filed (Month, Day, Year) JUL 24 1996													

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23467

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHANCEY LEON SHIREY				2. Date of Death Month JULY Day 18 Year 1996		3. Time of Death 05:42AM	
	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 217 10 5210		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 14, 1909	9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residence of Decedent							
10a. State Maryland		10b. County Allegany		10c. City, Town or Location Cresaptown		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number P.O. Box 5026				10f. Zip Code 21505		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineering		16b. Kind of Business/Industry Chemical		
17. Father's Name (First, Middle, Last) Harry L. Shirey				18. Mother's Name (First, Middle, Maiden Surname) Carrie Bowman				
19a. Informant's Name/Relationship (Type, Print) Catherine V. Shirey				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 5026 Cresaptown, MD 21505				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sunset Memorial Park		Data 7/20/96		20c. Location - City or Town, State Cumberland, MD		
21. Signature of Funeral Service Licensee <i>Nicholas Scarpelli</i>				22. Name and Address of Facility 108 Virginia Avenue Cumberland, MD 21502				
23a. Part 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. C.A.D. & ventricular tachycardia Due to (or as a consequence of): b. COPD & cancer metastases Due to (or as a consequence of): c. D.M. I.D. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Approximate Interval Between Onset and Death 1 hr 147 min 107 min								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number DO 8377		29d. Date signed (Month, Day, Year) JULY , 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) URIEL VELANDIA M.D. 924 SETON DRIVE CUMBERLAND, MD. 21502								
31. Date filed (Month, Day, Year) JUL 22 1996		32. Registrar's Signature <i>[Signature]</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23468

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Della Mae Turner				2. Date of Death Month July Day 22 Year 1996		3. Time of Death 7:45 P.M.	
	4e. Facility Name (If not institution, give street and number) 419 Red Pump Road				4b. City, Town, or Location of Death Bel Air		4c. County of Death Harford	
Funeral Director	5. Social Security Number 217-07-9217		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 98 Yrs.		8. Date of Birth (Month, Day, Year) 8/20/1897	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Md.		10b. County Harford		10c. City, Town or Location Bel Air	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 419 Red Pump Road		10f. Zip Code 21014		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress		16b. Kind of Business/Industry Government			
	17. Father's Name (First, Middle, Last) Nathaniel Jefferson Gover				18. Mother's Name (First, Middle, Maiden Surname) Martha Ann			
	19a. Informant's Name/Relationship (Type, Print) Audrey M. Kane				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 419 Red Pump Rd. Bel Air, Md. 21014			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation		Date 7/24/96		20c. Location - City or Town, State Hampstead, Md.	
	21. Signature of Funeral Service Licensee Benjamin W. Kurtz		22. Name and Address of Facility Jarretttsville, Md. 21084 Kurtz Funeral Home, P.A. P.O. Box 6					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cancer of Cervix							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Metastasis to Pelvis Congestive heart failure, Anemia							
	23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23d. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
23e. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Physician /Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) N/A		28b. Time of Injury N/A M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred N/A		28e. Location (Street and Number or Rural Route Number, City or Town, State)					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and Title of certifier Attending		29c. License number D-16444		29d. Date signed (Month, Day, Year) JULY-23rd 1996			
	30. Name and address of person who completed cause of death (item 23a) (Type, Print) VIJAY. S. NAIR M.D. - 2112 BELAIR ROAD, FALLSTON, MD. 21047							
	31. Date filed (Month, Day, Year) JUL 22 1996		32. Registrar's Signature Davidson-Randall					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23469

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALTHEA V. TWIGG				2. Date of Death Month Day Year JULY 20 1996		3. Time of Death 19:30	
	4a. Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL & MEDICAL CENTER				4b. City, Town, or Location of Death CUMBERLAND, MD		4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 220-34-1242		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) July 10, 1909	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Allegany		10c. City, Town or Location Cumberland	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1 Baltimore Street		10f. Zip Code 21502		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer		16b. Kind of Business/Industry Self-employed			
	17. Father's Name (First, Middle, Last) Richard Alva Browning Twigg				18. Mother's Name (First, Middle, Maiden Surname) Emma (Mortimer)			
	19a. Informant's Name/Relationship (Type, Print) Emma Twigg Clarke				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 E. Joppa RD, Ste. 304, Towson, MD. 21286-3004			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Hermon Cemetery		Date 7/24/96		20c. Location - City or Town, State Cumberland, MD.	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Kight Funeral Home 309-311 Decatur St., Cumberland, MD. 21502			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CHRONIC OBSTRUCTIVE LUNG DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 15 YEARS							
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how Injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D 14865		29d. Date signed (Month, Day, Year) JULY 21, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. R. BARRERA, MEMORIAL HOSPITAL MEDICAL BUILDING, CUMBERLAND, MD 21502								
31. Date filed (Month, Day, Year) JUL 23 1996				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 23470

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Albert Wheeler

2. Date of Death

July 20 1996

Day

Year

3. Time of Death

5:00pm

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

218-26-0006

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

Jan. 6, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Harford

10c. City, Town or Location

Street

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street end Number

1315 Whiteford Road

10f. Zip Code

21154

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII/

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Joseph Albert Wheeler

18. Mother's Name (First, Middle, Maiden Surname)

Marie (nmn) Colgan

19a. Informant's Name/Relationship (Type, Print)

Jessie K. Wheeler/ wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1315 Whiteford Road, Street, Maryland 21154

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of Place)

BEL AIR MEMORIAL GARDENS
St. Ignatius Cemetery

Date

7/23/96

20c. Location - City or Town, State

BEL AIR
Hickory, Maryland

21. Signature of Funeral Service Licensee

Howard K. McComas

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial infarction
Due to (or as a consequence of)

Approximate Interval Between Onset and Death

2 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Sepsis
Due to (or as a consequence of):

16 d

c. Colon perforation
Due to (or as a consequence of):

16 d

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Steroid dependent arthritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Scott A. Stennetz MD

29c. License number

D47463

29d. Date signed (Month, Day, Year)

7/19/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Scott A. Stennetz MD 2005 Rock Spring Rd. Forest Hill, Md. 21050

31. Date filed (Month, Day, Year)

JUL 22 1996

32. Registrar's Signature

John A. Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

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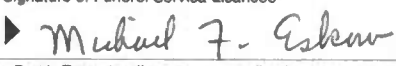

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 23471**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY LOUISE WOODWARD					2. Date of Death Month JULY Day 26 Year 1996		3. Time of Death 9:19 AM		
	4a. Facility Name (If not institution, give street and number) Memorial Hospital at Easton					4b. City, Town, or Location of Death Easton		4c. County of Death Talbot		
Funeral Director	5. Social Security Number 218-20-7075		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) 09/25/26		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State MD			10b. County Dorchester		10c. City, Town or Location Federalsburg			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 4813 Preston Road					10f. Zip Code 21632		10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) CHARLES LYDEN					18. Mother's Name (First, Middle, Maiden Surname) ELVA THAWLEY					
19a. Informant's Name/Relationship (Type, Print) Elmer S. Woodward					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4813 Preston Rd., Federalsburg, MD 21632					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Eastern Shore Vet.		Date 7/30/96		20c. Location - City or Town, State Hurlock, MD			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Frampton-Hawkins-Eskow Funeral Home PO Box 43, Federalsburg, MD 21632					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>a. CARDIAC EVENT / MYOCARDIAL ARREST Due to (or as a consequence of):</p> <p>b. CONGESTIVE HEART FAILURE Due to (or as a consequence of):</p> <p>c. Peripheral Vascular Disease Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 35%; text-align: center;"> <p>IMMED.</p> <p>10 YEARS</p> <p>YEARS</p> </div> </div>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 					29c. License number 045105		29d. Date signed (Month, Day, Year) 7/26/96 5pm			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Michelle Ong, M.D., 606 Dutchman's Lane, Easton, MD 21601										
31. Date filed (Month, Day, Year) JUL 31 '96			32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

**State
Registrar**

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

10
23472

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN BELL WAGNER, SR.				2. Date of Death Month July Day 26 Year 1996		3. Time of Death 2:03	
	4a. Facility Name (If not institution, give street and number) Memorial Hospital at Easton				4b. City, Town, or Location of Death Easton		4c. County of Death Talbot	
Funeral Director	5. Social Security Number 220-01-9328		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) 8/4/1911	
	9. Birthplace (State or Foreign Country) Tenn.		10a. State Md.		10b. County Caroline		10c. City, Town or Location Preston	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 4299 Poplar Neck Road		10f. Zip Code 21655		
10g. Citizen of What Country? U.S.A.		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plumber & Electrician		16b. Kind of Business/Industry Plumbing		
17. Father's Name (First, Middle, Last) Charles Crigger				18. Mother's Name (First, Middle, Maiden Surname) Margaret Crigger				
19a. Informant's Name/Relationship (Type, Print) Charles Wagner (son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 340 Glebe Road, Easton, Md. 21601				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Jr. Order Cemtery		20c. Location - City or Town, State 7/29/96 Preston, Md.		21. Signature of Funeral Service Licensee Michael F. Eskow		
22. Name and Address of Facility 216 N. Main St. Federalsburg Frampton-Hawkins-Eskow F.H. Md. 21632		23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ACUTE RENAL FAILURE Due to (or as a consequence of): ACUTE TUBULAR NECROSIS Due to (or as a consequence of): HEMORRHAGIC SHOCK 20 UGIBL Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CHRONIC D.M.		Approximate interval Between Onset and Death 48° 48° 48°		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier Kevin O'Keefe		29c. License number D35259		29d. Date signed (Month/Day, Year) 7/26/96		30. Name and address of person who completed cause of death (item 23e) (Type, Print) Kevin O'Keefe, M.D., 606 Dutchmans Lane, Easton, Maryland 21601		
31. Date filed (Month, Day, Year) JUL 29 '96		32. Registrar's Signature Gina Davidson-Randall						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

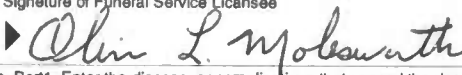
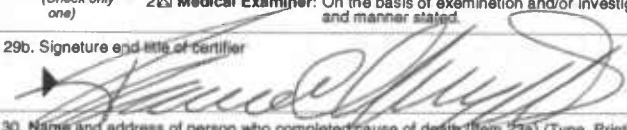
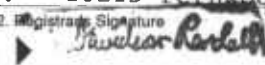
State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23473

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Irene H. Warthen				2. Date of Death Month Day Year July 21 1996		3. Time of Death 5:20 PM	
	4a. Facility Name (If not institution, give street and number) Wilson Health Care Center				4b. City, Town, or Location of Death Gaithersburg		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 214-36-4247	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 97 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 18, 1898		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Montgomery		10c. City, Town or Location Gaithersburg			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 301 Russell Avenue			10f. Zip Code 20877		10g. Citizen of What Country? American		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk			16b. Kind of Business/Industry U.S. Government		
	17. Father's Name (First, Middle, Last) Jason Phillips Warthen				18. Mother's Name (First, Middle, Maiden Surname) Charlotte Holden Reed			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Charlotte E. Dann - Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8900 McGregor Drive, Chevy Chase, Maryland 20815			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Damascus Cemetery		Date 7/25/96		20c. Location - City or Town, State Damascus, Maryland	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Olin L. Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0111				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction Due to (or as a consequence of): a. _____ b. _____ Due to (or as a consequence of): c. _____ d. _____ Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Fractured Left Hip						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) June 30 96		28b. Time of Injury P. M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Fell In Room
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home				28f. Location (Street and Number or Rural Route Number, City or Town, State) #10				
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of Certifier 				29c. License number D07099		29d. Date signed (Month, Day, Year) July 22, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Francis C. Mayle, M.D. - 10215 Fernwood Road, Bethesda, Maryland 20817								
31. Date filed (Month, Day, Year) JUL 27 1996		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23474

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) Clarence Chester WOLFE, Sr				2. Date of Death Month Day Year July 19, 1996		3. Time of Death 9:35am	
4a. Facility Name (If not institution, give street and number) College View Center				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
5. Social Security Number 219-20-0177		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sep 22, 1918	
9. Birthplace (State or Foreign Country) Maryland							
Usual Residence of Decedent							
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 700 Toll House Avenue				10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farming		16b. Kind of Business/Industry Agriculture	
17. Father's Name (First, Middle, Last) Chester Arthur WOLFE				18. Mother's Name (First, Middle, Maiden Surname) Nellie EICHELBERGER			
19a. Informant's Name/Relationship (Type, Print) Mrs. Margaret A. Wolfe				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1304 West Seventh Street, Frederick, MD 21702			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Mem Gardens		Date Jul 22, 1996		20c. Location - City or Town, State Frederick, Maryland	
21. Signature of Funeral Service Licensee <i>Robert M00706</i>				22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebrovascular accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):						Approximate Interval Between Onset and Death 24 hrs	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's Disease						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Austin Pearre</i>		29c. License number D09689		29d. Date signed (Month, Day, Year) July 22, 1996	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Austin Pearre, Jr, M.D., 300 West Ninth Street, Frederick, Maryland 21701							
31. Date filed (Month, Day, Year) JUL 22 1996				32. Registrar's Signature <i>Shirley Randall</i>			

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEM: 19a, PER F.H. FILM G-740

10/17/96 tt Items: 14, 16a, 18 per FH G-753 11/14/97 dh
Film G739 item 4a, 19b, 23a per FH & PH 9-12-96 rjs

State of Maryland / Department of Health and Mental Hygiene

96 23475

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HUEI LI WEN			2. Date of Death Month Day Year July 17, 1996		3. Time of Death 3:35 P.M.	
	4a. Facility Name (If not institution, give street and number) Lawnview 1821 Lawnview Drive			4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 212-94-0975		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 24, 1914
	9. Birthplace (State or Foreign Country) China						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10e. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 1821 Lawnview Dr.			10f. Zip Code 21702		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White Asian
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Financial Secretary		16b. Kind of Business/Industry Banking		
	17. Father's Name (First, Middle, Last) YU - LIN LI			18. Mother's Name (First, Middle, Maiden Surname) HU - TSE LI Hsi-Lin-Hu			
	19e. Informant's Name/Relationship (Type, Print) CHUNG HUET WEN / Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1821 Lawnview Dr. / Frederick, Maryland 21702			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory		20c. Location - City or Town, State 7-21-96 Hagerstown, Maryland		
	21. Signature of Funeral Service Licensee <i>Raymond Peterson</i>			22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, Maryland 21702			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.						
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) e. <i>metastatic Breast Cancer</i> Due to (or as a consequence of):						Approximate Interval Between Onset and Death 13 15 years
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. <i>Bony metastasis</i> Due to (or as a consequence of):						10 years
	c. <i>pulmonary edema</i> Due to (or as a consequence of):						One week
	d.						
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
	29b. Signature and title of certifier <i>Victor Chang</i>		29c. License number D 34969		29d. Date signed (Month, Day, Year) July 18, 1996		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Victor Chang 9407 Medical Center Drive, Suite 320, Rockville, MD 20850						
	31. Date filed (Month, Day, Year) JUL 29 1996		32. Registrar's Signature <i>Julia Davidson-Randall</i>				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23476
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EVELYN MARIE WEAVER				2. Date of Death Month Day Year July 26, 1996		3. Time of Death 4:42 A.		
	4a. Facility Name (If not institution, give street and number) Memorial Hospital & Medical Center				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany		
Funeral Director	5. Social Security Number 213-74-4531		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 95 Yrs.		8. Date of Birth (Month, Day, Year) Jan 22, 1901		
	9. Birthplace (State or Foreign Country) PA		10e. State MD		10b. County Allegany		10c. City, Town or Location Cumberland		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10f. Zip Code 21502		10g. Citizen of What Country? USA		10e. Street and Number Route 8 Box 342	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) William H. Flowers		18. Mother's Name (First, Middle, Maiden Surname) Elizabeth M. (Hostetler)		19a. Informant's Name/Relationship (Type, Print) Mary M. Lease--daughter	
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12021 Amherst Avenue NE; Cumberland, MD 21502		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Memorial Park		20c. Location - City or Town, State Cumberland, MD		20d. Date 07/30	
21. Signature of Funeral Service Licensee Nicholas Scarpelli		22. Name and Address of Facility Scarpelli Funeral Home Cumberland, MD 21502		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC HEART DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 10 years		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Adrenal insufficiency		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier John Barrera, Jr.		29c. License number D 14865		29d. Date signed (Month, Day, Year) JULY 27, 1996		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Barrera, Memorial Hospital, Medical Building Cumberland, MD 21502	
31. Date filed (Month, Day, Year) JUL 29 1996		32. Registrar's Signature John Davidson Randall		33. State Registrar		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	

96 23477

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GENEVIEVE CATHERINE WAGONER				2. DATE OF DEATH MONTH JUL DAY 14 , YEAR 1996		3. TIME OF DEATH 8:30 P.M.	
4. SOCIAL SECURITY NUMBER 220-16-5612		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jul 4, 1918	
9a. FACILITY NAME (If not institution, give street and number) 424 SOUTH STREET				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		9c. COUNTY OF DEATH ALLEGANY	
10a. STATE MD		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 424 South Street				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker		16b. KIND OF BUSINESS/INDUSTRY own home			
17. FATHER'S NAME (First, Middle, Last) Wesley J. Kipe, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Frances Bartik			
19a. INFORMANT'S NAME (Type/Print) Walter R. Wagoner - husband				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 424 South Street; Cumberland, MD 21502			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Mary's Cemetery		DATE 07/18		20c. LOCATION — City or Town, State Cumberland, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James F. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ACUTE RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST CHRONIC OBSTRUCTIVE LUNG DISEASE DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death 24 HRS 10 YRS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. METASTATIC CARCINOMA OF BREAST & THYROID							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other (Specify)		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>DR. N. RANJITHAN</i> M.D. (FOR DR. RANJITHAN)				29c. LICENSE NUMBER D19318 223334		29d. DATE SIGNED (Month, Day, Year) JUL 23 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. N. Ranjithan, M.D.; 517 Oldtown Road; Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) JUL 24 1996				32. REGISTRAR'S SIGNATURE <i>John H. Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended # 7, 7/23/96, NBS, Allegany County

96 23478

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Anna Brigitta Warner				2. DATE OF DEATH MONTH DAY YEAR July 17, 1996				3. TIME OF DEATH 1230 a m					
4. SOCIAL SECURITY NUMBER 379-10-5390		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 98 YRS.	7. DATE OF BIRTH (Month, Day, Year) Dec. 30, 1897		8. BIRTHPLACE (State or Foreign Country) Michigan							
9a. FACILITY NAME (If not institution, give street and number) Cumberland Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland				9c. COUNTY OF DEATH Allegany					
10a. STATE West Virginia		10b. COUNTY Mineral		10c. CITY, TOWN OR LOCATION Wiley Ford				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER Rt # 1, Box 35				10f. ZIP CODE 26767		10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home									
17. FATHER'S NAME (First, Middle, Last) Gustav Peterson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lisa (Nilson)									
19a. INFORMANT'S NAME (Type/Print) Elizabeth Wagner				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt #1, Box 35, Wiley Ford, WV 26767-9719									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) West Hill Cemetery 7/23/96		20c. LOCATION — City or Town, State Houghton, Michigan									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE William S. Kight				22. NAME AND ADDRESS OF FACILITY Kight Funeral Home 309-311 Decatur St., Cumberland, MD 21502									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Intestinal obstruction</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 4 days													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>coronary artery disease</u> Did tobacco use contribute to the cause of death? NO								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Sunil K. Gupta		29c. LICENSE NUMBER D 33280		29d. DATE SIGNED (Month, Day, Year) July 19, 1996							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Sunil K. Gupta 625 Kent Ave., Cumberland, MD. 21502													
31. DATE FILED (Month, Day, Year) JUL 23 1996				32. REGISTRAR'S SIGNATURE John Davidson Kendall									

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Forest Hill Cemetery 7/23/96 Houghton, Michigan
Knight Funeral Home
309-311 Decatur St., Cumberland, MD 21502

X
William B. Knight

96-4399-510

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-738 8/15/96 t.t

B.K.S ITEM: 1. PER MEO FILM G-738 8/14/96 t.t State of Maryland / Department of Health and Mental Hygiene

Film G737 item 1 per FH 8-8-96 rja

ITEM: 23 PART I, PER MEO FILM G-740 10/10/96 t.t

Certificate of Death

Reg. No.

96 23479

Physician
/Medical
Examiner1. Decedent's Name (First, Middle, Last) ~~GLEN~~ ~~ADKINS~~ ~~Atkins~~ ~~JR~~

2. Date of Death

Month Day Year
AUG. 05, 1996

3. Time of Death

1247 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

4208 LOCH RAVEN BLVD. APT.#419

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

214-76-5994

6. Sex

XXM 2□F

7. Age (In yrs. last birthday)

36

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JAN 14, 1960

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTO

10d. Inside City Limits

XXYes 2□No

10e. Street and Number

4208 LOCH RAVEN BLVD APT 419

10f. Zip Code

21239

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1□Never Married 2XXMarried

3□Widowed 4□Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1□Yes 2XXNo

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□Yes 2XXNo Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4or 5+)

n/a

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

TRUCK DRIVER

16b. Kind of Business/Industry

MEDICAL SUPPLY CO

17. Father's Name (First, Middle, Last)

GLEN ATKINS SR

18. Mother's Name (First, Middle, Maiden Surname)

DANELLA CARROLL

19a. Informant's Name/Relationship (Type, Print)

DANELLA JONES

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6800 PEACHTREE ATLANTA, GA 30360

20a. Method of Disposition

1□Burial 2□Cremation 3□Removal from State

4□Donation 5□Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MT. ZION CEM

Date

AUG 8

20c. Location - City or Town, State

BALTO, MD

21. Signature of Funeral Service Licensee

Patricia Betts

22. Name and Address of Facility

BETTS FUNERAL HOME

1129 N. CAROLINE ST BALTO, MD 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. ACUTE COCAINE INTOXICATION AND DROWNING

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1□Yes 2□No 3□Probably 4XXUnknown

24a. Was an autopsy
performed?

1XXYes 2□No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1XXYes 2□No

25. Was case referred to medical
examiner?
XXYes 2□No

26. Place of Death (Check only one)

Hospital:

1□Inpatient

2□ER/Outpatient

3□DOA

Other:

4□Nursing Home

XXResidence 8□Other (Specify)

27. Manner of Death

1□Natural

2□Accident

3□Suicide

4□Homicide

5□Pending investigation

6XXCould not be determined

28a. Date of Injury

(Month, Day Year)

FOUND 8-5-96

28b. Time of

Found

12:20 P M

28c. Injury at

Work?

1□Yes 2XXNo

28d. Describe how injury occurred

UNKNOWN

28a. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

FOUND AT HOME

28f. Location (Street and Number or Rural Route Number,
City or Town, State) 4208 LOCH RAVEN BLVD
BALTIMORE, MARYLAND29a. Certifier
(Check only
one)

1□Certifying Physician:

XXMedical Examiner:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis J. Chute MD

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

AUG. 6, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chute MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 08 1996

32. Registrar's Signature

Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23480

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ESTELLE ADCOCK				2. Date of Death Month Day Year July 29 1996		3. Time of Death 1:50 PM.	
	4a. Facility Name (If not institution, give street and number) Caton Manor 3330 Wilkens Ave.				4b. City, Town, or Location of Death Baltimore		4c. County of Death City	
Funeral Director	5. Social Security Number 214-50-6440		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) April 26 1909	
	9. Birthplace (State or Foreign Country) Virginia		10a. State Md.		10b. County City		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 3330 Wilkens Ave.		10f. Zip Code 21229		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) housewife		16b. Kind of Business/Industry Homeowner		17. Father's Name (First, Middle, Last) Reese Adcock	
	18. Mother's Name (First, Middle, Maiden Surname) Lula Branhan		19a. Informant's Name/Relationship (Type, Print) Evelyn Hildebrand/daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1513 Marshall St. Baltimore, Md. 21230		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Cemetery		20c. Date 8/1/96		20d. Location - City or Town, State Glen Burnie, Md.		21. Signature of Funeral Service Licensee <i>[Signature]</i>	
	22. Name and Address of Facility McCully Funeral Home 130 E. Fort Ave. Baltimore, Md. 21230		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Electrolyte imbalance/Dehydration Due to (or as a consequence of): b. Progressive Dysphagia Due to (or as a consequence of): c. Possible Cerebrovascular accident Due to (or as a consequence of): d. Approximate Interval Between Onset and Death four days few weeks +		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Ceeha Raja MD	
	29c. License number D27541		29d. Date signed (Month, Day, Year) July 29, 1996		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CREEHA RAJA 4367 Hollins Ferry Rd, Baltimore MD - 21227		31. Date filed (Month, Day, Year) AUG 08 1996	
State Registrar	32. Registrar's Signature <i>[Signature]</i>		33. Registrar's Title John A. [Signature]		34. Registrar's Address John A. [Signature]		35. Registrar's Phone Number John A. [Signature]	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23481

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Daniel L. Anthony

2. Date of Death

Month 8 Day 3 Year 1996

3. Time of Death

8:20pm

4a. Facility Name (If not institution, give street and number)

7638 Beach Road

4b. City, Town, or Location of Death

Pasadena

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

217-18-1466

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

2/4/22

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7638 Beach Road

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1942-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Purchasing Agent

16b. Kind of Business/Industry

American Can Co.

17. Father's Name (First, Middle, Last)

John Anthony

18. Mother's Name (First, Middle, Maiden Surname)

Margareite Williams

19a. Informant's Name/Relationship (Type, Print)

Mrs. Mary E. Anthony/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7638 Beach Road Pasadena, Maryland 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crownsville V.A. Ceme. 8/6/96

Date

20c. Location - City or Town, State

Crownsville, Md.

21. Signature of Funeral Service Licensee

Eugene J. Laster

22. Name and Address of Facility

McCully Funeral Home of Pasadena
3204 Mountain Road Pasadena, Maryland 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

metastatic rectal cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2mo

b.

rectal cancer

Due to (or as a consequence of):

2yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

coronary artery disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Lorraine M. Dailey MD

29c. License number

D21613

29d. Date signed (Month, Day, Year)

8/5/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. LORRAINE DAILEY, 8096 EDWIN RAYMOND BLVD. PASADENA, MD. 21122

31. Date filed (Month, Day, Year)

AUG 08 1996

32. Registrar's Signature

John H. ...

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23482

Film G737 item 20c per FH 8-8-96 rja

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM B. BARTHOLOMEW, SR.				2. Date of Death Month AUGUST Day 3 Year 1996		3. Time of Death 10:50 AM	
	4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL CENTER				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death City	
Funeral Director	5. Social Security Number 218-22-7825		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 24 1927	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Md.		10b. County City		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 1233 Patapsco Street				10f. Zip Code 21230		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WWII If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4or 5+) none		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Coater Operator		16b. Kind of Business/Industry National Can			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Edgar Bartholomew				18. Mother's Name (First, Middle, Maiden Surname) Margaret M. Long			
	19a. Informant's Name/Relationship (Type, Print) Irene A. Bartholomew/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1233 Patapsco Street Baltimore, Md. 21230			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crownsville V.A. Cemt.		Date 8/7/96		20c. Location - City or Town, State Crownsville, Md.	
	21. Signature of Funeral Service Licensee Daniel A. Taylor		22. Name and Address of Facility McCully Funeral Home 130 E. Fort Ave. Baltimore, Md. 21230					
Physician /Medical Examiner	23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death	
	a. PROBABLE INTRACRANIAL HEMORRHAGE Due to (or as a consequence of):						24 hours.	
	b. THROMBOCYTOPENIA Due to (or as a consequence of):						24 hours.	
	c. CHRONIC MYELOGENOUS LEUKEMIA Due to (or as a consequence of):						4 years.	
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HISTORY OF HASCVD, CVA, CHF, CRF, DM - INSULIN REQUIRING						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)	
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
			28g. Location (Street and Number or Rural Route Number, City or Town, State)					
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier Dr. Eren M.D.	
							29c. License number 1752441614-44	
							29d. Date signed (Month, Day, Year) AUGUST 3, 1996	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) FER EREN, M.D. HARBOR HOSPITAL 3001 S. Hancock St. Balto. Md. 21225							
State Registrar	31. Date filed (Month, Day, Year) AUG 08 1996		32. Registrar's Signature John Davidson-Randall					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23483

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GEORGE GILBERT BORAM				2. Date of Death Month Day Year AUG 5 1996		3. Time of Death 6^{am}																											
	4a. Facility Name (If not Institution, give street and number) 2305 Cider Mill Rd				4b. City, Town, or Location of Death PARKVILLE		4c. County of Death Balto																											
Funeral Director	5. Social Security Number 215-05-7529		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) JAN 23, 1912																											
	Usual Residence of Decedent		10a. State Md.		10b. County BALTIMORE		10c. City, Town or Location PARKVILLE																											
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 2305 Cider Mill Rd		10f. Zip Code 21234		10g. Citizen of What Country? USA																											
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII Korea		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE																											
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 3		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Col. U.S. Army		16b. Kind of Business/Industry MILITARY																													
	17. Father's Name (First, Middle, Last) ALBERT BORAM				18. Mother's Name (First, Middle, Maiden Surname) ANNA OTT																													
	19a. Informant's Name/Relationship (Type, Print) Richard F. BORAM / Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8311 AVONDALE Rd. Balto. Md. 21234																													
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ARLINGTON NATIONAL		20c. Date AUG 13 1996		20d. Location - City or Town, State ARLINGTON, VA.																											
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility EVANS CHAPEL of MEMORIES 8800 Harford Rd. Balto. Md. 21234																													
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																	
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. ADENOCARCINOMA of ? Primary</td> <td rowspan="4">Approximate Interval Between Onset and Death 1 1/2 yrs</td> </tr> <tr> <td>b. LIVER METASTASES vs 1^o TUMORS</td> </tr> <tr> <td>c. _____</td> </tr> <tr> <td>d. _____</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. ADENOCARCINOMA of ? Primary	Approximate Interval Between Onset and Death 1 1/2 yrs	b. LIVER METASTASES vs 1^o TUMORS	c. _____	d. _____																				
	Immediate Cause (Final disease or condition resulting in death)	a. ADENOCARCINOMA of ? Primary	Approximate Interval Between Onset and Death 1 1/2 yrs																															
b. LIVER METASTASES vs 1^o TUMORS																																		
c. _____																																		
d. _____																																		
<table border="1"> <tr> <td colspan="4">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</td> <td colspan="4">23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="4"></td> <td colspan="4">24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> <tr> <td colspan="4"></td> <td colspan="4">24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> </table>								Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																														
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																														
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																														
<table border="1"> <tr> <td colspan="2">25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="6">26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="2">27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide</td> <td colspan="2">28a. Date of Injury (Month, Day Year)</td> <td colspan="2">28b. Time of Injury M</td> <td colspan="2">28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="2">28d. Describe how Injury occurred</td> </tr> <tr> <td colspan="2"></td> <td colspan="4">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="3">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table>								25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
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		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																												
<table border="1"> <tr> <td colspan="8">29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</td> </tr> <tr> <td colspan="4">29b. Signature and title of certifier </td> <td colspan="2">29c. License number D28812</td> <td colspan="2">29d. Date signed (Month, Day, Year) 8/6/96</td> </tr> </table>								29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier 				29c. License number D28812		29d. Date signed (Month, Day, Year) 8/6/96												
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																		
29b. Signature and title of certifier 				29c. License number D28812		29d. Date signed (Month, Day, Year) 8/6/96																												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Vincent Di Pietro 7801 York Rd																																		
31. Date filed (Month, Day, Year) AUG 08 1996				32. Registrar's Signature 																														

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23484

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RUTH ANNA BREWSTER

2. Date of Death

Month Day Year
AUG 5, 1996

3. Time of Death

9 PM

4a. Facility Name (If not institution, give street and number)

ALLEGIOUS NURSING HOME

4b. City, Town, or Location of Death

OVERLEA

4c. County of Death

—

Funeral
Director

5. Social Security Number

217-24-6501

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 5, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

MD.

10b. County

—

10c. City, Town or Location

Balto

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

401 E. 25th ST

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)
—

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Sales Clerk

16b. Kind of Business/Industry

RETAIL

17. Father's Name (First, Middle, Last)

LESTER R. MERRITT

18. Mother's Name (First, Middle, Maiden Surname)

EFFIE MAY CUNNINGHAM

19e. Informant's Name/Relationship (Type, Print)

Mildred Thomas

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2902 Willoughby Rd BALTO. Md. 21234

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

Moreland Memorial Park

Date

Aug 9
1996

20c. Location - City or Town, State

Parkville, Md.

21. Signature of Funeral Service Licensee

Robert W. Graves

22. Name and Address of Facility

EVANS CHAPEL OF MEMORIES
8800 Harford Rd
BALTO. Md. 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. CARCINOMA OF LIVER

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical
examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

28. Place of Death (Check only one)

1 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

29e. Certifier
(Check only
one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Dr. Luis Rivera

29c. License number

D08344

29d. Date signed (Month, Day, Year)

8/7/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. Luis Rivera 5714 Harford Rd

31. Date filed (Month, Day, Year)

AUG 08 1996

32. Registrar's Signature

John Davidson-Rendell

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

The Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23485

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARIO L. BUSCEMI				2. Date of Death Month August Day 1 Year 1996		3. Time of Death 5:45 P.M.						
	4a. Facility Name (If not institution, give street and number) MAJOR CARE - Ruxton				4b. City, Town, or Location of Death Ruxton		4c. County of Death BALTIMORE						
Funeral Director	5. Social Security Number 215 25 7796	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) Dec. 2, 1908	9. Birthplace (State or Foreign Country) ITALY						
	Usual Residence of Decedent												
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County BALTIMORE	10c. City, Town or Location PHOENIX			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	10e. Street and Number 13416 JARRETTVILLE PIKE			10f. Zip Code 21131		10g. Citizen of What Country? U.S.A.							
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 YRS. College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SELF EMP		16b. Kind of Business/Industry STONE MASON							
	17. Father's Name (First, Middle, Last) JOHN BUSCEMI				18. Mother's Name (First, Middle, Maiden Surname) PAULA								
	19a. Informant's Name/Relationship (Type, Print) ABATHA BUSCEMI				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21131 13416 JARRETTVILLE PIKE PHOENIX, MARYLAND								
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) OLNEY VALLEY MEMORIAL		20c. Location - City or Town, State 1996 TIMONIUM, MARYLAND		20d. Date AUG. 5						
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility EVANS CHAPEL OF CHIMES 2025 YORK ROAD - TIMONIUM								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Acute Stroke</td> <td rowspan="4">Approximate Interval Between Onset and Death 1 Month</td> </tr> <tr> <td>b. Due to (or as a consequence of):</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Acute Stroke	Approximate Interval Between Onset and Death 1 Month	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. Acute Stroke	Approximate Interval Between Onset and Death 1 Month											
	b. Due to (or as a consequence of):												
	c. Due to (or as a consequence of):												
	d. Due to (or as a consequence of):												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No							
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred									
28f. Location (Street and Number or Rural Route Number, City or Town, State)													
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. Signature and title of certifier 				29c. License number D-12849		29d. Date signed (Month, Day, Year) AUGUST 5, 1996							
30. Name and address of person who completed cause of death (item 23e) (Type, Print) DR. A.H. GHILAOI 7600 OSLER DRIVE TOWSON, MARYLAND 21204													
31. Date filed (Month, Day, Year) AUG 08 1996				32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

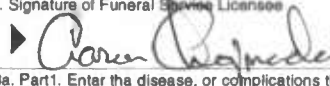
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23486

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GRACE M. BANGS				2. Date of Death Month Aug. Day 2 Year 1996		3. Time of Death 4PM	
	4a. Facility Name (If not Institution, give street and number) HARBOR HOSPITAL CENTER				4b. City, Town, or Location of Death Baltimore, Md.		4c. County of Death City	
Funeral Director	5. Social Security Number 219-05-8684		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 2, 1920	
	9. Birthplace (State or Foreign Country) Maryland							
Usual Residence of Decedent								
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 3713 Seventh Street				10f. Zip Code 21225		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4or 5+) N/A				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Clerk			16b. Kind of Business/Industry State of Maryland	
17. Father's Name (First, Middle, Last) Leland Marcus Houghtling				18. Mother's Name (First, Middle, Maiden Surname) Anna Barbara Zeller				
19a. Informant's Name/Relationship (Type, Print) Mr. Patrick E. Bangs (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3713 Seventh Street Baltimore, Maryland 21225				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date 8/5/96		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Mc Cully Funeral Home of Brooklyn 237 East Patapsco Avenue Baltimore, MD. 21225				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. URINARY Sepsis Due to (or as a consequence of): CEREBROVASCULAR DISEASE Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death 1 day 5 years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. obstructive lung disease osteoporosis								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier John HARRY MD		29c. License number D21716		29d. Date signed (Month, Day, Year) 8/3/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN HARRY								
31. Date filed (Month, Day, Year) AUG 08 1996		32. Registrar's Signature John H. Randall						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23487

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CLARA C. DACHILLE		2. Date of Death Month Day Year AUGUST 6, 1996		3. Time of Death 3:20 AM
	4a. Facility Name (If not institution, give street and number) SAINT JOSEPH MEDICAL CENTER		4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE
Funeral Director	5. Social Security Number 214-12-9087	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) OCT 18, 1922		9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Timonium
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 1824 Vista Lane		10f. Zip Code 21093
	10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. College (1-4 or 5+)
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Book Keeper		16b. Kind of Business/Industry Shurwood Hills Liquors		17. Father's Name (First, Middle, Last) Walerity Jaromin
	18. Mother's Name (First, Middle, Maiden Surname) Marya Wozniak		19a. Informant's Name/Relationship (Type, Print) William R. Dachille, husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1824 Vista Lane Timonium, Maryland 21093
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens		20c. Location - City or Town, State Timonium, Maryland
	21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility Evans Chapel of Chimes Timonium, Md. 21093		23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CEREBRAL HEMORRHAGE
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
29b. Signature and title of certifier [Signature]		29c. License number D 46673		29d. Date signed (Month, Day, Year) 8/6/96	
30. Name and address of person who completed cause of death (item 23a) (Type, Print) A. H. GUARINO, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204		31. Date filed (Month, Day, Year) AUG 08 1996		32. Registrar's Signature [Signature]	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Immediate Cause (Final disease or condition resulting in death)

a. **CEREBRAL HEMORRHAGE**

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No25. Was case referred to medical examiner?
☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 46673

29d. Date signed (Month, Day, Year)

8/6/96

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

A. H. GUARINO, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

AUG 08 1996

32. Registrar's Signature

[Signature]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23488

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RENEE DORRIS				2. Date of Death Month 8 Day 5 Year 96		3. Time of Death 12:25 AM		
	4a. Facility Name (If not institution, give street and number) Genesis multi medical 7700 York Rd. Balto MD				4b. City, Town, or Location of Death Towson		4c. County of Death Towson		
Funeral Director	5. Social Security Number 444-26-8908		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JAN. 23, 1918	9. Birthplace (State or Foreign Country) TEXAS	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE CITY		10d. Inade City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 4973 DENMORE AVENUE, APT. #10				10f. Zip Code 21215		10g. Citizen of What Country? USA.		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10TH GRADE College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC WORKER		18b. Kind of Business/Industry SAM PROCTOR				
	17. Father's Name (First, Middle, Last) FRANK THOMAS				18. Mother's Name (First, Middle, Maiden Surname) ELLA BAXTER				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) CLEOLA KING				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4008 DERBY MANOR DRIVE, BALTO, MD. 21215				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY		20c. Location - City or Town, State 8-9-96 BALTIMORE, MARYLAND		21. Signature of Funeral Service Licensee 		
	22. Name and Address of Facility JOSEPH H. BROWN JR., FUNERAL HOME, P. A. 2140 N. FULTON AVE., BALTIMORE, MD. 21217				23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CEREBROVASCULAR ACCIDENT				
	Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT				Due to (or as a consequence of): 1 WEEK				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hypertension Hypothyroidism				Due to (or as a consequence of): 1 WEEK				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DRY GANGRENE OF FEET Hypertension Hypothyroidism						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number D21680		29d. Date signed (Month, Day, Year) AUGUST 5, 1996			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 6717 Park Heights Avenue Baltimore									
31. Date filed (Month, Day, Year) AUG 08 1996		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23489

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) <i>Clarence Darden</i>				2. Date of Death Month <i>August</i> Day <i>1</i> Year <i>1996</i>		3. Time of Death <i>5:00 AM</i>	
4a. Facility Name (If not institution, give street and number) <i>Maryland General Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore City</i>		4c. County of Death <i>N/A</i>	
5. Social Security Number <i>214-26-3775</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>68</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>FEB 9, 1928</i>	
Usual Residence of Decedent				9. Birthplace (State or Foreign Country) <i>NC</i>			
10a. State <i>MD</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>BALTO</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>1240 MAPLELEAF CT</i>				10f. Zip Code <i>21202</i>		10g. Citizen of What Country? <i>U.S.A.</i>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) <i>N/A</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>LABORER</i>		16b. Kind of Business/Industry <i>CONSTRUCTION CO</i>	
17. Father's Name (First, Middle, Last) <i>WILLIE DARDEN</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>ELLEN UNKNOWN</i>			
19a. Informant's Name/Relationship (Type, Print) <i>WILLIE DARDEN</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1837 E 29th st BALTO, MD 21218</i>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>MT. ZION CEM</i>		Date <i>AUG 6 1996</i>		20c. Location - City or Town, State <i>BALTO, MD</i>	
21. Signature of Funeral Service Licensee <i>Patricia Belts</i>				22. Name and Address of Facility <i>BETTS FUNERAL HOME</i> <i>1129 N. CAROLINE ST BALTO, MD 21213</i>			
23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. SQUAMOUS CELL CANCER of the Tonsills</i> Due to (or as a consequence of): <i>b. Chronic Obstructive Pulmonary Disease</i> Due to (or as a consequence of): <i>c. Emphysema</i> Due to (or as a consequence of): <i>d.</i>							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury et Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>J. F. D. M.D.</i>				29c. License number <i>89269</i>		29d. Date signed (Month, Day, Year) <i>August 1, 1996</i>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Gervacio Diaz, M.D. 40 Maryland General Hospital</i>							
31. Date filed (Month, Day, Year) <i>AUG 08 1996</i>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

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State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23490

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>James A. Dale</i>				2. Date of Death Month <i>8</i> Day <i>5</i> Year <i>96</i>		3. Time of Death <i>1:00PM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Anne Arundel Medical Center</i>				4b. City, Town, or Location of Death <i>Annapolis</i>		4c. County of Death <i>A.A.</i>	
Funeral Director	5. Social Security Number <i>209-34-6454</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>48</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) <i>10/18/47</i>	9. Birthplace (State or Foreign Country) <i>Pennsylvania</i>
	Usual Residence of Decedent							
10a. State <i>MD</i>		10b. County <i>A.A.</i>		10c. City, Town or Location <i>Arnold</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <i>1447 Point Way</i>				10f. Zip Code <i>21012</i>		10g. Citizen of What Country? <i>U.S.</i>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>Vietnam</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <i>5+</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Assistant Director of Music and Organist</i>		16b. Kind of Business/Industry <i>Civil Service</i>		
17. Father's Name (First, Middle, Last) <i>Hugh William Dale</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Elizabeth Wetmore</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Richard Edson Dale/Brother</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>27 Oakglade Dr. Hummelstown, PA 17036</i>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Metro Crematory, Inc. 8/6/96</i>		Date		20c. Location - City or Town, State <i>Baltimore, MD</i>		
21. Signature of Funeral Service Licensee <i>Dawn F. McDonald</i>				22. Name and Address of Facility <i>Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Staphylococcal Septicemia</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d. Due to (or as a consequence of):</i>								Approximate interval Between Onset and Death <i>6 days</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Richard N. Peeler, M.D.</i>		29c. License number <i>D12452</i>		29d. Date signed (Month, Day, Year) <i>Aug 5 '96</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>RICHARD N. PEELER, M.D., 900 BESTGATE RD. ANNAPOLIS, Md.</i>								
31. Date filed (Month, Day, Year) <i>AUG 8 1996</i>		32. Registrar's Signature <i>John Davidson</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23491

Items: 24a, 26 per M.D G-738 8/8/96 reb

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

GILDA H. FREEDMAN

2. Date of Death

AUGUST 2, 1996

3. Time of Death

10:50 PM

4a. Facility Name (If not institution, give street and number)

BRIGHTWOOD-MERIDIAN NURSING HOME

4b. City, Town, or Location of Death

LUTHERVILLE

4c. County of Death

BALTIMORE

5. Social Security Number

219-10-4780

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

NOV. 12, 1927

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

RANDALLSTOWN

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3522 CABOT ROAD

10f. Zip Code

21133

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

SAMUEL

HIKEN

18. Mother's Name (First, Middle, Maiden Surname)

ANNA

COHEN

19a. Informant's Name/Relationship (Type, Print)

ALLEN FREEDMAN (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3522 CABOT RD; RANDALLSTOWN, MD 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

OHEB SHALOM

Date

8/4/96

20c. Location - City or Town, State

REISTERSTOWN, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Sol Levinson & Bros., Inc.

8900 Reisterstown Road Pikesville, MD 21208

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic Intraabdominal Endometrial Carcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kenneth L. Glick MD 20 Crossroads Drive Suite 12 Owings Mills MD 21117-5419

31. Date filed (Month, Day, Year)

AUG 08 1996

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

96 23492

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY MARGARET FITZPATRICK						2. Date of Death Month Day Year AUGUST 1, 1996		3. Time of Death 11 A.M.	
	4a. Facility Name (If not institution, give street and number) 8105 RIGGETTOWN DRIVE APT. J.						4b. City, Town, or Location of Death PERRY HALL		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 212-38-1267		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 56		8. Date of Birth (Month, Day, Year) SEPT. 5, 1939		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location PERRY HALL				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 8105 RIGGETTOWN DRIVE				10f. Zip Code 21236		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS. College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) AT HOME			16b. Kind of Business/Industry -		
	17. Father's Name (First, Middle, Last) FRANK FRANCIS FITZPATRICK						18. Mother's Name (First, Middle, Maiden Surname) MARY M. McDONNELL			
	19a. Informant's Name/Relationship (Type, Print) DOROTHY A. FITZPATRICK				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 BANDOON COURT TIMONIUM, MARYLAND 21093					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) DULANEY VALLEY MEMORIAL		20c. Location - City or Town, State Timonium, MARYLAND		20d. Date of Disposition AUG 3 1996			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility EVANS FUNERAL CHAPEL - BELAIR, P.A. 21050 3 NEWPORT DRIVE FOREST HILL, MARYLAND					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD DIABETES									
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined										
28a. Date of Injury (Month, Day, Year)										
28b. Time of Injury M										
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
28d. Describe how Injury occurred										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 										
29c. License number 032543										
29d. Date signed (Month, Day, Year) AUGUST 2, 1996										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. MARK R. STROMBERG 7505 OLER DRIVE - Towson, MARYLAND										
31. Date filed (Month, Day, Year) AUG 08 1996										
32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

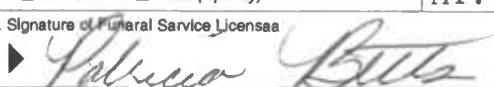
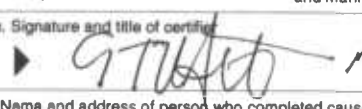
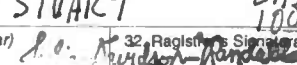
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23493

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIE FOSTER						2. Date of Death Month Day Year AUGUST 3, 1996		3. Time of Death 1:15 PM			
	4a. Facility Name (If not Institution, give street and number) 519 N. EAST AVE						4b. City, Town, or Location of Death BALTO		4c. County of Death N/A			
Funeral Director	5. Social Security Number 248-14-9578		6. Sex 13M 2F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) AUG 8, 1910		9. Birthplace (State or Foreign Country) SC			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State MD		10b. County N/A		10c. City, Town or Location BALTO				10d. Inside City Limits XX Yes 2 No			
	10e. Street and Number 519 N. EAST AVE				10f. Zip Code 21205		10g. Citizen of What Country? U.S.A.					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4or 5+) N/A			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BRICK LAYER			16b. Kind of Business/Industry CONSTRUCTION CO					
	17. Father's Name (First, Middle, Last) GOLDEN FOSTER						18. Mother's Name (First, Middle, Maiden Surname) MAMMIE BROWNING					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) MARIE BEBRON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 519 N. EAST AVE BALTO, MD 21205							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEM		Data AUG 7 1996		20c. Location - City or Town, State BALTO, MD					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility BETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO, MD 21213							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. NON SMALL CELL Lung Cancer Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 8 mths.	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  MD		29c. License number D17131		29d. Date signed (Month, Day, Year) 8-07-96						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GODO FREDO 4 STUART EAST BALTIMORE MEDICAL CENTER 1000 Eager Street, BALTO MD 21202												
31. Date filed (Month, Day, Year) AUG 08 1996		32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23494

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CATHERINE S. FRAME				2. Date of Death Month Day Year AUGUST 07 1996		3. Time of Death 7:10 AM		
	4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 218 18 5613		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) 11 09 24		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Md.		10b. County N/A		10c. City, Town or Location Baltimore		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2904 Hudson Street		10f. Zip Code 21224		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bookkeeper		16b. Kind of Business/Industry Continental Can					
17. Father's Name (First, Middle, Last) Joseph Schnepf				18. Mother's Name (First, Middle, Maiden Surname) Emma Berends					
19a. Informant's Name/Relationship (Type, Print) Louise Foltyn, Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7630 Daniels Ave. Balto., Md. 21234					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith		Date 8-10-96		20c. Location - City or Town, State Overlea, Md.			
21. Signature of Funeral Service Licensee Charles S. Zeiler				22. Name and Address of Facility Charles S. Zeiler & Son Inc. 6224 Eastern Ave. Balto., Md.					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PERFORATED VISCUS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 5 DAYS	
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29f. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29g. Signature and title of certifier Neeru Gupta, M.D.				29c. License number P09302		29d. Date signed (Month, Day, Year) AUGUST 7, 1996			
30. Name and address of person who completed causa of death (Item 23e) (Type, Print) NEERU GUPTA, M.D. 5601 LOCH RAVEN BOULEVARD BALTIMORE, MD 21286									
31. Date filed (Month, Day, Year) AUG 08 1996		32. Registrar's Signature Davidson-Randall							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23495

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Michael Wayne Flannagan

2. Date of Death

Month Day Year
July 22 1996

3. Time of Death

1420

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

218 42 3576

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 12, 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Somerset

10c. City, Town or Location

Marion Station

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4155 Back Shelltown Rd.

10f. Zip Code

21838

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
unknown

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Laborer

18b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

Sadie

unknown

19a. Informant's Name/Relationship (Type, Print)

Barbara Flannagan / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4155 Back Shelltown Rd., Marion Station, MD 21838

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Green Mount Crematory 8/8/96

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CAFA Stephen D. Lohrmann P.A.

8717 Green Pastures Dr., Baltimore, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Due to (or as a consequence of):

bowel necrosis

Approximate
Interval Between
Onset and Death

4 hours

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

Hosp # C3605

29d. Date signed (Month, Day, Year)

July 22, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Peter J. Gruber Johns Hopkins Hospital.

31. Date filed (Month, Day, Year)

AUG 08 1996

32. Signature of Registrar

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
00202.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be attached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

47 VA

1. The first part of the report
describes the general situation
of the country and the
state of the economy.

2. The second part of the report
describes the results of the
survey and the findings of the
study.

3. The third part of the report
describes the conclusions of the
study and the recommendations
for further action.

4. The fourth part of the report
describes the appendix and the
references.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN		2. Date of Death Month AUGUST Day 2 Year 1996		3. Time of Death 11:41A.M
	4a. Facility Name (If not institution, give street and number) 416 POPLAR STREET		4b. City, Town, or Location of Death WESTERNPORT		4c. County of Death ALLEGANY
Funeral Director	5. Social Security Number 077-30-6681	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 57 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth JUNE 30, 1939		9. Birthplace (State or Foreign Country) New York		
To Be Completed by Funeral Director	10a. State Maryland		10b. County Allegany		10c. City, Town or Location Westernport
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number 416 Poplar Street		10f. Zip Code 21562		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korea		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DISABLED		16b. Kind of Business/Industry N/A
	17. Father's Name (First, Middle, Last) Joseph Gorrone		18. Mother's Name (First, Middle, Maiden Surname) Caroline Carolyn Agnes Ruppert		
	19a. Informant's Name/Relationship (Type, Print) Heather Gorrone/daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1611 Taylor Ave. Bronx, NY 10460		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. 8/7/96		20c. Location - City or Town, State Baltimore, MD
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME, P.A. 404 DECATUR STREET, CUMBERLAND, MD 21502		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. NARCOTIC AND ALCOHOL INTOXICATION				Approximate Interval Between Onset and Death
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Were an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day, Year) FOUND 8/2/96					
28b. Time of Injury 10:30 A M					
28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how Injury occurred UNKNOWN					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) RESIDENCE					
28f. Location (Street and Number or Rural Route Number, City or Town, State) 416 POPLAR ST. WESTERNPORT, MD.					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 					
29c. License number O.C.M.E.					
29d. Date signed (Month, Day, Year) AUGUST 3, 1996					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DONALD G. WRIGHT M.D. 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) AUG 0 8 1996					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23497

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MAXIMILLIAN HANEKE				2. Date of Death Month AUGUST Day 3 Year 1996		3. Time of Death 3:00 a.m.		
	4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL CENTRE, 3001 S. HANOVER ST				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death		
Funeral Director	5. Social Security Number 215-28-8801	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 10, 1906		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Arnold			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 1419 Jones Station Road			10f. Zip Code 21012		10g. Citizen of What Country? U.S.A.			
	11. Marital Status unknown <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 4-8-27 If Yes, Give Year or Dates: 7-8-47 to		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 0			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Various			
	17. Father's Name (First, Middle, Last) Henry Haneke				18. Mother's Name (First, Middle, Maiden Surname) Catherine rocklitz				
	19a. Informant's Name/Relationship (Type, Print) Stewart I. Phipps/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1014 Wharf Road-Arnold, Maryland 21012				
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Date		20c. Location - City or Town, State				
	21. Signature of Funeral Service Licensee Ronald S. Wade, Dir.				22. Name and Address of Facility State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) e. ACUTE PULMONARY EDEMA Due to (or as a consequence of): b. CONGESTIVE HEART FAILURE Due to (or as a consequence of): c. COPD Due to (or as a consequence of): d. HYPERTENSION								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CELLULITIS PARKINSONISM ABDOMINAL AORTIC ANEURISM								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier V. Chandrasekhar Reddy PGYI				29c. License number AS 2441614-48	
29d. Date signed (Month, Day, Year) AUGUST 3 1996				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) V. CHANDRASEKHAR REDDY, HARBOR HOSPITAL CENTRE, 3001 S HANOVER ST, BALTIMORE					
31. Date filed (Month, Day, Year) AUG 08 1996				32. Registrar's Signature Johanna...					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Handwritten signature

300 4.14.11

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles Robert Harper			2. Date of Death Month August Day 6 Year 1996		3. Time of Death 1:08 pm		
	4a. Facility Name (If not institution, give street and number) Washington County Hospital			4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington		
Funeral Director	5. Social Security Number 224-42-0225		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 7, 1934	
	9. Birthplace (State or Foreign Country) Virginia							
To Be Completed by Funeral Director	Usual Residence of Decedent			10d. Inside City Limits 1 Yes 2 No				
	10a. State Virginia		10b. County Rockingham		10c. City, Town or Location Harrisonburg			
	10e. Street and Number Route 5 Box 241			10f. Zip Code 22801		10g. Citizen of What Country? USA		
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Tractor Trailer			
	17. Father's Name (First, Middle, Last) George W. Harper			18. Mother's Name (First, Middle, Maiden Surname) Catherine Lydia Garber				
	19a. Informant's Name/Relationship (Type, Print) Peggy H. Harper			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 5 Box 241, Harrisonburg, VA 22801				
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Horeb Cemetery		Date Aug. 9		20c. Location - City or Town, State Hinton, Virginia	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122				
	23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Multiple Injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
24a. Was an autopsy performed? 1 Yes 2 No							24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day, Year) 8/6/96		28b. Time of Injury 10:20 AM		28c. Injury at Work? 1 Yes 2 No		
		28d. Describe how injury occurred subject driver of truck struck bridge abutment		28e. Location (Street and Number or Rural Route Number, City or Town, State) Interstate 81 South of Maryland State Line, Washington County, Maryland				
29a. Certifier (Check only one) 2 Medical Examiner		29b. Signature and title of certifier 						
		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) August 7, 1996				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) THE DOORE MARY		111 Penn Street, Baltimore, Maryland 21201						
31. Date filed (Month, Day, Year) AUG 08 1996		Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 23499

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ORA M. HERRON				2. Date of Death Month August Day 6TH Year 1996		3. Time of Death 9:15pm		
	4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL				4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 213 26 0106		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 7, 1923	9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent								
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Baltimore			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10a. Street and Number 5209 Ballman Avenue				10f. Zip Code 21225		10g. Citizen of What Country? U.S.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker			16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) John Wesley Carmony					18. Mother's Name (First, Middle, Maiden Surname) Martha McConnel				
19a. Informant's Name/Relationship (Type, Print) Wanda Jones / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7107 Lindale Woods Glen Burnie, Maryland 21061					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park		Date 8/10/96		20c. Location - City or Town, State Glen Burnie, Maryland		
21. Signature of Funeral Service Licensee <i>Anna M. Zanciouski</i>				22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEVERE PERIPHERAL VASCULAR DISEASE. ONE YEAR Due to (or as a consequence of): b. CORONARY ARTERY DISEASE TWO YEARS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS.									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
			28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <i>[Signature]</i> MD			29c. License number D48006		29d. Date signed (Month, Day, Year) AUGUST 6TH, 1996	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOFI OWusu-BOWITEY, 301 HOSP. DR, GLEN BURNIE, 21061									
31. Date filed (Month, Day, Year) AUG 08 1996			32. Registrar's Signature <i>[Signature]</i>						

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 23500

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CATHERINE L. HAYLEY

2. Date of Death

August 4, 1996

3. Time of Death

4:30 AM

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Balto

4c. County of Death

NIA

Funeral
Director

5. Social Security Number

176-20-5027

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 10, 1925

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

NIA

10c. City, Town or Location

Balto

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2045 Braddish Ave

10f. Zip Code

21216

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

2 yrs

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Executive Secretary

16b. Kind of Business/Industry

Social Security Admin

17. Father's Name (First, Middle, Last)

Leonard B. Thomas

18. Mother's Name (First, Middle, Maiden Surname)

Emma C. Pierce

19a. Informant's Name/Relationship (Type, Print)

Walter E. Hayley - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5538 Vantage Pt. Rd Columbia, Md 21044

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Necropolis, crematory or other place)

Crownsville Veteran

Date

8/4/96

20c. Location - City or Town, State

Gounsville, Md

21. Signature of Funeral Service Licensee

Portia Elton

22. Name and Address of Facility

March E. West
4300 Wabash Ave

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. HYPOTENSION
Due to (or as a consequence of):

b. ACUTE RENAL FAILURE
Due to (or as a consequence of):

c. SHOCK
Due to (or as a consequence of):

d. SEPSIS

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

E. Host

29c. License number

AS240232/EH/8500

29d. Date signed (Month, Day, Year)

August 4, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E. Host Sinai Hospital 2401 W. Belverdere Ave Balto, Md 21215

31. Date filed (Month, Day, Year)

UG 0 8 1996

32. Registrar's Signature

Julia Davidson

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division Vital Records, P.O. Box 68760,

